



Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>5,574</u>	<u>5,574</u>	8
9	SNF/PED					9
10	ICF	<u>86,746</u>	<u>483</u>	<u>7,228</u>	<u>94,457</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>86,746</u>	<u>483</u>	<u>12,802</u>	<u>100,031</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.28%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 07/01/14

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/01/14 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 3,324

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	409,669	107,570	18,148	535,387		535,387		535,387		1
2	Food Purchase		506,438		506,438	(1,840)	504,598	(24)	504,574		2
3	Housekeeping	1,830	40,350	316,890	359,070		359,070		359,070		3
4	Laundry		31,288	157,456	188,744		188,744		188,744		4
5	Heat and Other Utilities			305,297	305,297		305,297	(7,850)	297,447		5
6	Maintenance	184,031	52,973	111,636	348,640		348,640	43,255	391,895		6
7	Other (specify):*							560	560		7
8	<b>TOTAL General Services</b>	595,530	738,619	909,427	2,243,576	(1,840)	2,241,736	35,942	2,277,678		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,830	10,830		10,830		10,830		9
10	Nursing and Medical Records	4,406,379	705,358	44,777	5,156,514		5,156,514	(51,374)	5,105,140		10
10a	Therapy	20,680			20,680		20,680		20,680		10a
11	Activities	100,032	12,834	1,485	114,351		114,351		114,351		11
12	Social Services	351,892		543	352,435		352,435		352,435		12
13	CNA Training										13
14	Program Transportation			5,545	5,545		5,545		5,545		14
15	Other (specify):*							2,335	2,335		15
16	<b>TOTAL Health Care and Programs</b>	4,878,983	718,192	63,180	5,660,355		5,660,355	(49,039)	5,611,316		16
	<b>C. General Administration</b>										
17	Administrative	154,981		1,001,159	1,156,140		1,156,140	(962,880)	193,260		17
18	Directors Fees										18
19	Professional Services			196,745	196,745	(8,734)	188,011	(25,162)	162,849		19
20	Dues, Fees, Subscriptions & Promotions			83,927	83,927		83,927	(54,182)	29,745		20
21	Clerical & General Office Expenses	330,158	38,961	568,823	937,942		937,942	(194,872)	743,070		21
22	Employee Benefits & Payroll Taxes			1,139,122	1,139,122	1,840	1,140,962		1,140,962		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,342	7,342		7,342	503	7,845		24
25	Other Admin. Staff Transportation							7,793	7,793		25
26	Insurance-Prop.Liab.Malpractice			968,222	968,222		968,222	20,836	989,058		26
27	Other (specify):*							27,420	27,420		27
28	<b>TOTAL General Administration</b>	485,139	38,961	3,965,340	4,489,440	(6,895)	4,482,545	(1,180,544)	3,302,002		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,959,652	1,495,772	4,937,947	12,393,371	(8,734)	12,384,637	(1,193,641)	11,190,995		29

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

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; Reh C

#0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			107,320	107,320		107,320	267,752	375,072			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,193	128,193		128,193	416,890	545,083			32
33	Real Estate Taxes					8,734	8,734	420,190	428,924			33
34	Rent-Facility & Grounds			1,513,397	1,513,397		1,513,397	(1,509,393)	4,004			34
35	Rent-Equipment & Vehicles			46,292	46,292		46,292	3,652	49,944			35
36	Other (specify):*							78,900	78,900			36
37	<b>TOTAL Ownership</b>			1,795,202	1,795,202	8,734	1,803,936	(322,009)	1,481,927			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		259,100	982,994	1,242,094		1,242,094	(20,810)	1,221,284			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			747,744	747,744		747,744		747,744			42
43	Other (specify):*	121,792			121,792		121,792	(121,792)	0			43
44	<b>TOTAL Special Cost Centers</b>	121,792	259,100	1,730,738	2,111,630		2,111,630	(142,602)	1,969,028			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,081,444	1,754,872	8,463,887	16,300,203		16,300,203	(1,658,252)	14,641,951			45

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

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	(11,750)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(81,431)	30		9
10	Interest and Other Investment Income	(204)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	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	(4,668)	21		18
19	Entertainment	(1,219)	24		19
20	Contributions	(15,080)	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	(399,852)	21		24
25	Fund Raising, Advertising and Promotional	(36,279)	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	(378,477)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (928,984)</b>		<b>\$</b>	<b>30</b>

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)	(729,268)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (729,268)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,658,252)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

## California Gardens N &amp; Reh C

Report Period Beginning: 01/01/14  
 Ending: 12/31/14

ID# 0040022

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Patient Needs	\$ (8,462)	10	1
2				2
3	Veteran's Expense	(67,801)	10	3
4	Bank Charges	(17,464)	21	4
5	Guest Relation Salary	(37,316)	43	5
6	Sequestration Fee	(43,599)	21	6
7	Misc. Income - Record Copies	(1,280)	21	7
8	Jury Duty Income	(103)	10	8
9	Gain on Sale of Fixed Asset	(24,871)	30	9
10	Building Company - License and Inspection	(100)	20	10
11	Building Company - Professional Fees	(17,348)	19	11
12	Building Company - Amortization	(5,712)	36	12
13	Annual Report	(175)	20	13
14	Collections	(23,928)	21	14
15	Web Media	(195)	21	15
16				16
17	Non-Allowable Legal	(36,997)	19	17
18	Additional R&M	4,907	06	18
19	Marketing Salary	(84,476)	43	19
20	COPE Dues	(4,660)	20	20
21	Non-Allowable Fees	(8,898)	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>		(378,477)	49

California Gardens N & Reh C

ID# 0040022

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number California Gardens N & Reh C# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	(24)											(24)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,750)		3,900									(7,850)	5
6	Maintenance	4,907	19,918	18,430									43,255	6
7	Other (specify):*			560									560	7
8	<b>TOTAL General Services</b>	<b>(6,867)</b>	<b>19,918</b>	<b>22,891</b>									<b>35,942</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(76,366)		26,361			(1,369)						(51,374)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,335									2,335	15
16	<b>TOTAL Health Care and Programs</b>	<b>(76,366)</b>		<b>28,696</b>			<b>(1,369)</b>						<b>(49,039)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(962,880)									(962,880)	17
18	Directors Fees													18
19	Professional Services	(54,345)	17,348	11,835									(25,162)	19
20	Fees, Subscriptions & Promotions	(56,294)	100	2,012									(54,182)	20
21	Clerical & General Office Expenses	(499,884)		305,012									(194,872)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,219)		1,722									503	24
25	Other Admin. Staff Transportation			7,793									7,793	25
26	Insurance-Prop.Liab.Malpractice		19,947	889									20,836	26
27	Other (specify):*			27,420									27,420	27
28	<b>TOTAL General Administration</b>	<b>(611,742)</b>	<b>37,395</b>	<b>(606,197)</b>									<b>(1,180,544)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(694,974)</b>	<b>57,313</b>	<b>(554,611)</b>			<b>(1,369)</b>						<b>(1,193,641)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	(106,302)	360,914	13,140									267,752	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(204)	413,916	3,178									416,890	32
33	Real Estate Taxes		414,955	5,235									420,190	33
34	Rent-Facility & Grounds		(1,509,987)	594									(1,509,393)	34
35	Rent-Equipment & Vehicles			3,652									3,652	35
36	Other (specify):*	(5,712)	84,612										78,900	36
37	<b>TOTAL Ownership</b>	<b>(112,218)</b>	<b>(235,590)</b>	<b>25,799</b>									<b>(322,009)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(8,684)	(7,167)	(4,959)						(20,810)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(121,792)											(121,792)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(121,792)</b>			<b>(8,684)</b>	<b>(7,167)</b>	<b>(4,959)</b>						<b>(142,602)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(928,984)	(178,277)	(528,812)	(8,684)	(7,167)	(6,328)						(1,658,252)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<a href="#">See Page 6-Supplemental</a>		<a href="#">See Page 6-Supplemental</a>		<a href="#">See Page 6-Supplemental</a>		

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	\$ 1,509,987	California Gardens Associates	100.00%	\$	\$ (1,509,987)	1
2	V	32 Interest	730	California Gardens Associates	100.00%	414,646	413,916	2
3	V	06 Repairs-Building		California Gardens Associates	100.00%	19,918	19,918	3
4	V	26 Gen. and Professional Liability		California Gardens Associates	100.00%	19,947	19,947	4
5	V	20 License and Inspection		California Gardens Associates	100.00%	100	100	5
6	V	19 Professional Fees		California Gardens Associates	100.00%	17,348	17,348	6
7	V	33 Real Estate Taxes		California Gardens Associates	100.00%	414,955	414,955	7
8	V	30 Depreciation		California Gardens Associates	100.00%	360,914	360,914	8
9	V	36 Amortization of Loan Fees		California Gardens Associates	100.00%	5,712	5,712	9
10	V	36 Mortgage Insurance Expense		California Gardens Associates	100.00%	78,900	78,900	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,510,717			\$ 1,332,440	\$ * (178,277)	14

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

Facility Name & ID Number California Gardens N & Reh C# 0040022Report Period Beginning: 01/01/14Ending: 12/31/14

## 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%	\$ 3,900	\$ 3,900
16	V	6 MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	6,322	6,322
17	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	12,108	12,108
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	560	560
19	V	10 CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	26,361	26,361
20	V	15 EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	2,335	2,335
21	V	17 ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	38,279	38,279
22	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	11,835	11,835
23	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	2,012	2,012
24	V	21 CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	256,927	256,927
25	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	48,084	48,084
26	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,722	1,722
27	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	7,793	7,793
28	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	889	889
29	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	27,420	27,420
30	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	13,140	13,140
31	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	3,178	3,178
32	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	5,235	5,235
33	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	594	594
34	V	35 AUTO LEASE		NUCARE SERVICES CORP.	100.00%	3,652	3,652
35	V						
36	V	17 BOOKKEEPING FEES	1,001,159	NUCARE SERVICES CORP.	100.00%		(1,001,159)
37	V						
38	V						
39	Total		\$ 1,001,159			\$ 472,347	\$ * (528,812)

\* 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	39 DME & MEDICAL SUPPLIES	\$ 94,034	INTEGRA HEALTHCARE EQUIPMENT		\$ 85,350	\$ (8,684)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 94,034			\$ 85,350	\$ * (8,684)

\* 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	39 RESPIRATORY SERVICES	\$ 34,380	INTEGRA RESPIRATORY SERVICES LLC		\$ 27,213	\$ (7,167)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 34,380			\$ 27,213	\$ * (7,167)

\* 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	10 Ambulance	\$ 5,896	Lifeline Ambulance	100.00%	\$ 4,527	\$ (1,369)
16	V	39 Ambulance	21,362	Lifeline Ambulance	100.00%	16,403	(4,959)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 27,258			\$ 20,930	\$ * (6,328)

\* 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	\$ 130,772	MAPLE LEAF INSURANCE	100.00%	\$ 130,772	\$	15
16	V	26 Liability Insurance	700,397	MAPLE LEAF INSURANCE	100.00%	700,397		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		\$ 831,169			\$ 831,169	\$ *	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:	
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:	
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

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARRY & RANDY CARR	4.750%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REI	CHICAGO	CALIFORNIA GARDENS ASSOC	LINCOLNWOOD	BUILDING CO.	1
2	GARY HOKIN	14.521%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	MAPLE LEAF INSURANCE	GRAND CAYMAN	LIABILITY INSURANCE	2
3	GERRY JENICH	5.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	RAJCHENBACH FAMILY TRUST	4.750%	JACKSON CORP.	CHICAGO				4
5	ROBERT HARTMAN	55.750%	MONROE CORP.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	5
6	MARK HOLLANDER DISCRETIONARY TRUST	1.583%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING	6
7	SHARON HOLLANDER DISCRETIONARY TRUST	1.583%	ARIA POST ACUTE CARE	HILLSIDE	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	7
8	FEIGE C. KNOBEL DISCRETIONARY TRUST	1.584%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	8
9	DAVID HOKIN	10.479%	THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPLIES	9
10			RENAISSANCE EAST	MESA, ARIZONA	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	10
11			RENAISSANCE PARK SOUTH,LLC	CHICAGO	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERV.	11
12			RENAISSANCE VILLAGE AL	MESA, ARIZONA				12
13			RENAISSANCE VILLAGE IL	MESA, ARIZONA				13
14			RENAISSANCE WEST	MESA, ARIZONA				14
15			CLAREMONT - HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										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

Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 1,239,904	17	\$ 44,608	\$	108,405	\$ 3,900	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS 1,239,904	17	72,310	72,310	108,405	6,322	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 1,239,904	17	138,492		108,405	12,108	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS 1,239,904	17	6,405		108,405	560	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS 1,239,904	17	301,506	301,506	108,405	26,361	5
6	15	EMPLOYEE BENEFITS - CLIN	AVAIL. CENSUS DAYS 1,239,904	17	26,708		108,405	2,335	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS 1,239,904	17	437,828	437,828	108,405	38,279	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 1,239,904	17	135,365		108,405	11,835	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 1,239,904	17	23,010		108,405	2,012	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS 1,239,904	17	2,938,655	2,938,655	108,405	256,927	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 1,239,904	17	549,976		108,405	48,084	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 1,239,904	17	19,695		108,405	1,722	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 1,239,904	17	89,139		108,405	7,793	13
14	26	INSURANCE	AVAIL. CENSUS DAYS 1,239,904	17	10,164		108,405	889	14
15	27	EMPLOYEE BENEFITS - ADM	AVAIL. CENSUS DAYS 1,239,904	17	313,624		108,405	27,420	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS 1,239,904	17	150,292		108,405	13,140	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 1,239,904	17	36,349		108,405	3,178	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 1,239,904	17	59,877		108,405	5,235	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 1,239,904	17	6,796		108,405	594	19
20	35	AUTO LEASE	AVAIL. CENSUS DAYS 1,239,904	17	41,766		108,405	3,652	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,402,565	\$ 3,750,299		\$ 472,347	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Integra Healthcare Equipment, LLC  
 Street Address 747 Church Road  
 City / State / Zip Code Elmhurst, IL 60126  
 Phone Number ( 630) 834-3700  
 Fax Number ( 630) 834-1500

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	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 85,350	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				\$	\$		\$ 85,350	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Integra Respiratory Services LLC

Street Address

747 Church Road

City / State / Zip Code

Elmhurst, IL 60126

Phone Number

( 630) 834-3700

Fax Number

( 630) 834-1500

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	39	RESPIRATORY SERVICES	DIRECT ALLOCATION		\$	\$		\$ 27,213	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				\$	\$		\$ 27,213	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Lifeline Ambulance LLC  
 Street Address 2424 S. Wabash Avenue  
 City / State / Zip Code Chicago, IL 60616  
 Phone Number ( 312) 949-9595  
 Fax Number ( 312) 949-9262

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	AMBULANCE	DIRECT ALLOCATION		\$	\$		\$ 4,527	1
2	39	AMBULANCE	DIRECT ALLOCATION					16,403	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				\$	\$		\$ 20,930	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Maple Leaf Insurance  
 Street Address PO Box 69, 720 West Bay Rd  
 City / State / Zip Code Grand Cayman, KY1-1102  
 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	22	WORKERS COMPENSATION	Direct Allocation		\$	\$		\$ 130,772	1
2	26	LIABILITY INSURANCE	Direct Allocation					700,397	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				\$	\$		\$ 831,169	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	HUD Loan		X	Mortgage			\$	\$ 14,430,201			\$ 414,646	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Bank of America		X	Working Capital - LOC				2,620,000				6					
7	The Private Bank		X	Working Capital - LOC				115,114			128,193	7					
8	See Supplemental Schedule										3,178	8					
9	<b>TOTAL Facility Related</b>						\$	\$ 17,165,315			\$ 546,017	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income		X								(204)	10					
11	Interest Income - Building Co.		X								(730)	11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (934)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 17,165,315			\$ 545,083	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,900 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.)

\*\* 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 & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	<b>TOTAL Long-Term</b>															
	<b>Working Capital</b>															
8	Allocated from NuCare		X				\$	\$			\$ 3,178					
9																
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>										3,178					
	<b>B. Non-Facility Related*</b>															
15							\$	\$			\$					
16																
17																
18																
19																
20	<b>TOTAL Non-Facility Related</b>															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<b>423,942</b>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>414,453</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(9,489)</b>		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>429,679</b>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>8,734</b>		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>31,565</u> For <u>2000-2002 2011</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>428,924</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>386,745</u>			8
	2010	<u>403,582</u>			9
	2011	<u>362,311</u>			10
	2012	<u>403,754</u>			11
	2013	<u>409,218</u>			12
<b>2014 Accrual = \$409,218 x 1.05 = \$429,679</b>					
<b>Allocated from NuCare: \$5,235</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2013	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

**NOTES:**

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



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

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

C.    **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

# 0040022 Report Period Beginning:

01/01/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>193,025</u>	<u>1987</u>	<u>\$ 300,000</u>	<u>1</u>
2	<u>Allocated from NuCare 7257 N. Lincoln Ave.</u>		<u>2004</u>	<u>9,373</u>	<u>2</u>
3	<b>TOTALS</b>	<b>193,025</b>		<b>\$ 309,373</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	297		1977	\$ 4,708,760	\$ 360,914		\$ 176,340	\$ (184,574)	\$ 3,239,794	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1981	4,471		20			205	9
10	Various		1982	2,319		20				10
11	Various		1983	10,829		20			1,580	11
12	Various		1984	1,410		20			277	12
13	Various		1985	17,805		20			492	13
14	Various		1986	22,863		20			6,764	14
15	Various		1987	40,100		20			13,868	15
16	Various		1988	2,787		20			2,787	16
17	Various		1989	3,024		20			1,348	17
18	Various		1990	8,652		20			4,290	18
19	Various		1991	3,892		20			2,125	19
20	Various		1993	24,138		20			15,589	20
21	Various		1994	8,195		20	376	376	5,703	21
22	Various		1995	17,230		20	856	856	16,934	22
23	Various		1996	46,848		20	2,342	2,342	42,861	23
24	Various		1997	70,702		20	3,482	3,482	62,309	24
25	Various		1998	33,854		20	1,693	1,693	28,010	25
26	Various		1999	103,092		20	5,155	5,155	79,803	26
27	Various		2000	194,600		20	9,730	9,730	143,972	27
28	Various		2001	75,921		20	3,796	3,796	51,451	28
29	Various		2002	45,162		20	1,685	1,685	40,669	29
30	Various		2003	55,404		20	2,213	2,213	45,835	30
31	Various		2004	32,888		20	901	901	19,477	31
32	Various		2005	23,434		20	1,059	1,059	19,373	32
33	Various		2006	22,990		20	971	971	21,309	33
34	Various		2008	6,857		20	343	343	2,086	34
35	Various		2009	420,531		20	22,539	22,539	127,728	35
36	Various		2010	89,028		20	9,054	9,054	44,058	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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		648,765			43,153	43,153	259,291	67
68		156,699	6,338		6,067	(271)	54,987	68
69			82,449			(82,449)		69
70		\$ 6,903,251	\$ 449,701		\$ 291,753	\$ (157,948)	\$ 4,355,195	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,903,251	\$ 449,701		\$ 291,753	\$ (157,948)	\$ 4,355,195	1
2	2000 Linear Ft. Chair Railoak Color For 2Nd Floor	2011	4,390		20	439	439	1,756	2
3	2005 Linera Ft Chair Rail 5/8" X 2 1/2	2011	4,341		20	434	434	1,700	3
4	2 Custom Wraparound Ss Grab Bars, 2 Shower Rods, 2 Grab Bar	2011	2,856		20	286	286	1,047	4
5	1 Commercial Gas Water Heater	2011	6,807		20	1,361	1,361	4,992	5
6	Shower Room, 4 Wrap Around Grab Bars, 4 Shower Rods, 4 24" C	2011	4,784		20	478	478	1,675	6
7	Grab Bars/Remodeling For 3Rd Floor Shower Room	2011	4,924		20	492	492	1,683	7
8	Fire Pump Repair	2011	3,069		20	153	153	588	8
9	Elevator Repairs	2012	4,149		20	415	415	1,072	9
10	Door Levers	2012	5,465		20	547	547	1,139	10
11	Elevator Repair	2012	2,970		20	297	297	891	11
12	Elevator Repair	2012	3,059		20	306	306	663	12
13	Elevator Repair	2012	3,017		20	302	302	629	13
14	Signs & Wiring On 1St Floor, Room 120	2013	2,720		20	136	136	272	14
15	Kitchen-Floor Drain & 8 Ft. Of Cast Iron Pipe	2013	4,200		20	210	210	315	15
16	Light Fixtures Under Front Of Building Canopy & Windows	2013	4,510		20	226	226	451	16
17	Framing & Drywall, Acoustical, Painting, Hvac For All	2014			20				17
18	Resident Bathrooms	2014	139,961		20	2,099	2,099	2,099	18
19	Injection Pump	2014	3,011		20	125	125	125	19
20	Fire Alarm Sprinkler System Work	2014	8,771		20	146	146	146	20
21	Conduit And Wire, Misc Pipe Fiting Fire Alarm	2014	2,852		20	71	71	71	21
22	Ran Rg 59/18 Cable To 12 Existing Cameras Located In The Ceilin	2014	8,200		20	137	137	137	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)		\$ 7,127,308	\$ 449,701		\$ 300,414	\$ (149,287)	\$ 4,376,646	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 7,127,308	\$ 449,701		\$ 300,414	\$ (149,287)	\$ 4,376,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 7,127,308	\$ 449,701		\$ 300,414	\$ (149,287)	\$ 4,376,646	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,127,308	\$ 449,701		\$ 300,414	\$ (149,287)	\$ 4,376,646	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)		\$ 7,127,308	\$ 449,701		\$ 300,414	\$ (149,287)	\$ 4,376,646	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 7,127,308	\$ 449,701		\$ 300,414	\$ (149,287)	\$ 4,376,646		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)	\$ 7,127,308	\$ 449,701		\$ 300,414	\$ (149,287)	\$ 4,376,646		34

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

Facility Name &amp; ID Number California Gardens N &amp; Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Various	2004	18,253		20	1,435	1,435	14,480	9
10	Various	2005	147,095		20	14,526	14,526	140,791	10
11	Interlocking Door Parts	2007	3,821		20	191	191	1,528	11
12	Clear Polish Wire Glass - 3 Rooms	2007	3,148		20	157	157	1,257	12
13	Clear Polish Wire Glass - 1 Room	2007	485		20	24	24	193	13
14	Cooling Tower	2007	36,990		20	1,850	1,850	14,799	14
15	2 Passenger Elevator	2007	6,721		20	336	336	2,688	15
16	Electrical Work	2007	17,065		20	853	853	6,825	16
17	Smoke Detectors and Standard Wire Bases	2007	3,509		20	175	175	1,401	17
18	Motor - Cooling Tower	2007	4,110		20	206	206	1,647	18
19	Tadiran IPx500 Telephone System	2008	21,467		20	2,147	2,147	15,029	19
20	Carpet; Armstrong Beckford	2008	7,103		20	355	355	2,485	20
21	Remote Annunciator Panel for Basement Generator	2008	3,852		20	193	193	1,351	21
22	Headend Installation and Home Run Wiring to Roof	2008	13,039		20	1,304	1,304	9,128	22
23	Change Heights of Outlets	2008	2,625		20	131	131	917	23
24	Video Monitoring System	2008	3,713		20	186	186	1,302	24
25	Outdoor Lighting	2008	8,415		20	421	421	2,947	25
26	CCTV to Monitor Floors	2008	3,469		20	173	173	1,211	26
27	Varieties of Burning Bushes	2008	8,175		20	409	409	2,863	27
28	Installation of Video Multiplexer Recorder	2008	2,710		20	136	136	952	28
29	Asphalt Paving Work	2008	4,350		20	218	218	1,526	29
30	Landscape Irrigation System	2008	18,000		20	900	900	6,300	30
31	New Elevator Door	2008	9,221		20	461	461	3,227	31
32	CABLE WIRING	2013	2,780		20	510	510	1,019	32
33	LAVATORY FAUCETS	2013	11,187		20	932	932	1,864	33
34	TOTAL (lines 1 thru 33)		\$ 361,303	\$		\$ 28,229	\$ 28,229	\$ 237,731	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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 12F, Carried Forward		\$ 361,303	\$		\$ 28,229	\$ 28,229	\$ 237,731	1
2	WI-FI WIRING	2013	7,500		20	1,125	1,125	2,250	2
3	HOT WATER STORAGE TANK	2013	4,202		20	280	280	560	3
4	VOLTAGE OUTLETS FOR KIOSKS	2013	4,625		20	540	540	1,079	4
5	14 FIRE DAMPERS	2013	8,352		20	348	348	696	5
6	COMPRESSOR FOR WALK-IN FREEZER	2013	4,391		20	732	732	1,464	6
7	BLINDS, CABINETS, COUNTERTOPS, VINYL FLOORING	2013	3,910		20	782	782	1,564	7
8	RECOVERED AWNING	2013	2,665		20	244	244	489	8
9	SPRINKLER SYSTEM	2013	3,437		20	286	286	573	9
10	REPLACE BOILER	2013	8,758		20	219	219	438	10
11	60' CAST IRON PIPING	2013	12,000		20	300	300	600	11
12	RADIATOR RECORE	2013	3,720		20	310	310	620	12
13	SEWER CLEANOUT STATION	2013	9,800		20	327	327	653	13
14	Furnish and Install 19 2-hr Fire Dampers at floor to floor penetrati	2013	19,600		20	1,143	1,143	2,287	14
15	Sprinkler System	2014	7,014		20	351	351	351	15
16	Flooring - Ceramic Tiles - 3rd & 4th Floor Shower/Tub Room	2014	10,987		20	549	549	549	16
17	3 Elevators-Install Door Restrictors, Emergency Phones,				20				17
18	Code Data Plates, Emergency Light Battery, Alarm Bells	2014	20,951		20	1,048	1,048	1,048	18
19	3rd&4th FL Shower Room-Install Faucets, Grab Bars, Tiles	2014	28,800		20	1,440	1,440	1,440	19
20	Roof	2014	98,000		20	4,900	4,900	4,900	20
21	Parking Lot Paving	2014	28,750						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)		\$ 648,765	\$		\$ 43,153	\$ 43,153	\$ 259,291	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from NuCare 7257 N Lincoln Ave	2004	84,353	2,163	20	2,410	247	26,812	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Allocated from NuCare	2003	1,024	67	20	51	(16)	569	9
10	Allocated from NuCare	2004	20,791	1,361	20	1,041	(320)	11,149	10
11	Allocated from NuCare	2005	1,233	81	20	62	(19)	607	11
12	Allocated from NuCare	2006	1,671	109	20	84	(25)	699	12
13	Allocated from NuCare	2008	1,762	115	20	88	(27)	551	13
14	Allocated from NuCare	2009	28,364	1,856	20	1,418	(438)	7,956	14
15	Allocated from NuCare	2010	4,359	285	20	218	(67)	982	15
16	Allocated from NuCare	2011	236	15	20	12	(3)	46	16
17	Allocated from NuCare	2012	262	17	20	13	(4)	36	17
18	Allocated from NuCare	2014	3,278	215	20	99	(116)	99	18
19									19
20	Allocated from NuCare 7257 N Lincoln Ave	2005	7,690	54	20	487	433	4,601	20
21	Allocated from NuCare 7257 N Lincoln Ave	2004	1,676		20	84	84	880	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>		\$ 156,699	\$ 6,338		\$ 6,067	\$ (271)	\$ 54,987	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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 12H, Carried Forward		\$ 156,699	\$ 6,338		\$ 6,067	\$ (271)	\$ 54,987	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 156,699	\$ 6,338		\$ 6,067	\$ (271)	\$ 54,987	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 841,307	\$ 5,900	\$ 68,179	\$ 62,279	10	\$ 576,228	71
72	Current Year Purchases	57,511	851	6,225	5,374	10	6,225	72
73	Fully Depreciated Assets	654,225		99	99	10	654,223	73
74								74
75	TOTALS	\$ 1,553,042	\$ 6,751	\$ 74,503	\$ 67,752		\$ 1,236,676	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 FORD WAGON	1997	\$ 21,161	\$	\$	\$	5	\$ 21,160	76
77		Alloc from NuCare	2014	775	51	155	104	5	684	77
78										78
79										79
80	TOTALS			\$ 21,936	\$ 51	\$ 155	\$ 104		\$ 21,844	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)	\$ 9,011,659	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 456,503	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 375,072	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (81,431)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,635,166	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	Hallway Remodeling - Painting	\$ 93,800	92
93	Reception/offices/1st Floor Restrooms/restroom	169,530	93
94			94
95		\$ 263,330	95

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

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning: 01/01/14

Ending: 12/31/14

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				3,410			5
6	Allocated from NuCare (Parking Lot)				594			6
7	TOTAL				\$ 4,004			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. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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: \$ 37,205

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford Van Gohen	\$	\$ 9,087	17
18	Allocated from NuCare			3,652	18
19					19
20					20
21	TOTAL		\$	\$ 12,739	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.

Facility Name & ID Number California Gardens N & Reh C # 0040022 Report Period Beginning: 01/01/14 Ending: 12/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

<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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 413,351	\$		\$ 413,351	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			103,264			103,264	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			448,319			448,319	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				171,005		171,005	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>					18,060	88,095		106,155	13
14	TOTAL			\$		\$ 982,994	\$ 259,100		\$ 1,242,094	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.

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 9,051	\$ 476,684	1
2	Cash-Patient Deposits	44,424	44,424	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	4,577,819	4,691,460	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	20,000	20,000	5
6	Prepaid Insurance	3,896	25,926	6
7	Other Prepaid Expenses	6,108	6,108	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	38,979	1,014,337	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 4,700,277</b>	<b>\$ 6,278,939</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	1,198,636	7,218,418	15
16	Equipment, at Historical Cost	1,293,400	2,258,681	16
17	Accumulated Depreciation (book methods)	(1,988,220)	(8,871,546)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		199,903	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,948)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	46,900	161,900	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 550,716</b>	<b>\$ 6,082,228</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 5,250,993</b>	<b>\$ 12,361,167</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,289,709	\$ 1,289,708	26
27	Officer's Accounts Payable		112,358	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,735,114	2,735,114	29
30	Accrued Salaries Payable	386,283	386,283	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,970	25,970	31
32	Accrued Real Estate Taxes(Sch.IX-B)		429,679	32
33	Accrued Interest Payable		34,272	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,880	9,880	35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	1,254,595	1,254,595	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 5,701,551</b>	<b>\$ 6,277,859</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,430,201	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$ 14,430,201</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 5,701,551</b>	<b>\$ 20,708,060</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ (450,558)</b>	<b>\$ (8,346,893)</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 5,250,993</b>	<b>\$ 12,361,167</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (169,873)	1
2	Restatements (describe):		2
3	Workers' Comp Insurance	39,795	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (130,078)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(320,480)	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)	\$ (320,480)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (450,558)	24 *

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

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,115,905	1
2	Discounts and Allowances for all Levels	(1,563,795)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 12,552,110</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,714,408	6
7	Oxygen	4,607	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,719,015</b>	<b>8</b>
<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	531,695	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,935	19
20	Radiology and X-Ray	8,420	20
21	Other Medical Services	33,525	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 650,575</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	10	24
25	Interest and Other Investment Income***	204	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 214</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	57,809	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 57,809</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 15,979,723</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,243,576	31
32	Health Care	5,660,355	32
33	General Administration	4,489,440	33
<b>B. Capital Expense</b>			
34	Ownership	1,795,202	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,363,886	35
36	Provider Participation Fee	747,744	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 16,300,203</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(320,480)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (320,480)</b>	<b>43</b>

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,839,968	44
45	Private Pay - Net Inpatient Revenue	133,145	45
46	Medicare - Net Inpatient Revenue	462,098	46
47	Other-(specify)	486,629	47
48	Other-(specify)	630,270	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 12,552,110</b>	<b>49</b>

\* 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.

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	1,857	2,206	\$ 115,739	\$ 52.47	1
2	Assistant Director of Nursing	1,953	2,166	91,466	42.23	2
3	Registered Nurses	32,002	35,757	1,039,576	29.07	3
4	Licensed Practical Nurses	62,221	68,037	1,866,677	27.44	4
5	CNAs & Orderlies	103,919	111,979	1,225,194	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,633	1,789	20,680	11.56	8
9	Activity Director	1,915	2,093	37,543	17.94	9
10	Activity Assistants	5,384	6,173	62,489	10.12	10
11	Social Service Workers	14,090	14,884	250,733	16.85	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,246	65,751	29.27	13
14	Head Cook	6,901	7,899	123,892	15.68	14
15	Cook Helpers/Assistants	20,103	22,318	220,026	9.86	15
16	Dishwashers					16
17	Maintenance Workers	9,545	10,520	184,031	17.49	17
18	Housekeepers	141	153	1,830	11.96	18
19	Laundry					19
20	Administrator	1,991	2,086	108,201	51.87	20
21	Assistant Administrator					21
22	Other Administrative	481	481	46,780	97.26	22
23	Office Manager					23
24	Clerical	12,786	14,121	330,158	23.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,941	2,086	33,371	16.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	14,043	15,499	257,307	16.60	33
34	TOTAL (lines 1 - 33)	294,939	322,493	\$ 6,081,444 *	\$ 18.86	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	384	\$ 18,148	01-03	35
36	Medical Director	Monthly	10,830	09-03	36
37	Medical Records Consultant	Monthly	24,850	10-03	37
38	Nurse Consultant	4	202	10-03	38
39	Pharmacist Consultant	Monthly	19,725	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,485	11-03	44
45	Social Service Consultant	9	543	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	424	\$ 75,783		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

**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	
Alison Elsner	Administrator	0%	\$ 108,201	Workers' Compensation Insurance	\$ 227,050	IDPH License Fee	\$	
Tony Prather	Regional Director	0%	24,879	Unemployment Compensation Insurance	146,712	Advertising: Employee Recruitment	350	
Marilyn Flaherty	Medicare Reimb	0%	8,791	FICA Taxes	441,490	Health Care Worker Background Check		
Sondra Mixdorf	VP Clinical	0%	13,109	Employee Health Insurance	276,819	(Indicate # of checks performed <u>468</u> )	6,797	
				Employee Meals	1,840	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Trade Association Dues	9,460	
				Pension	26,587	Dues and Subscriptions	1,277	
				Other Employee Benefits	15,561	Licenses and Permits	9,849	
				401K Matching	4,904	Advertising and Promotions	36,279	
						See Supplemental Schedule	2,012	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(36,279)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 154,981	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,140,961	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 29,745	
(List each licensed administrator separately.)								
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
Bookkeeping Fee -NuCare Services Corp			\$ 1,001,159				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,001,159	TOTAL		\$	Seminar Expense	6,123
(Attach a copy of any management service agreement)							Allocated from NuCare	1,722
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg, & Rothblatt	Accounting Fees		\$ 23,955					
McGladrey LLP	Accounting Fees		822					
See Attached	Legal		63,370					
Personal Planners Inc.	Unemployment Consultant		3,118					
Ability Network Inc.	Computer Services		2,746					
CDW Government	Computer Services		1,062					
Creative Technology Solutions	Computer Services		22,266					
Emdeon	Computer Services		1,153					
E-Health Data Solutions	Computer Services		5,112					
Formation Healthcare Group	Computer Services		1,005					
HDSI Health Data Systems	Computer Services		5,612					
See Supplemental Schedule			66,523					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 196,745					
(For legal fee disclosure, see page 39 of instructions)								

\* Attach copy of IMRF notifications

\*\*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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number California Gardens N &amp; Reh C

# 0040022

Report Period Beginning:

01/01/14

Ending:

12/31/14

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on Long Term Care \$14,120
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line N/A
- (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. \$ 747,744  
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. \$ 1,840 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.