



Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning: 01/01/16 Ending: 12/31/16

**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	297	Skilled (SNF)	297	108,702	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	297	TOTALS	297	108,702	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,798	2,798	8
9	SNF/PED					9
10	ICF	35,357	1,388	62,239	98,984	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,357	1,388	65,037	101,782	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.63%

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 07/01/2014

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 07/01/2014 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 2,798

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number California Gardens N & Reh C # 0040022 Report Period Beginning: 01/01/16 Ending: 12/31/16

**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	377,546	53,951	21,211	452,708		452,708		452,708		1
2	Food Purchase		527,778		527,778	(1,889)	525,889	(72)	525,817		2
3	Housekeeping		380,888		380,888		380,888		380,888		3
4	Laundry		205,204		205,204		205,204		205,204		4
5	Heat and Other Utilities			299,730	299,730		299,730	(10,543)	289,187		5
6	Maintenance	174,180		153,396	327,576		327,576	35,608	363,184		6
7	Other (specify):*							5,037	5,037		7
8	<b>TOTAL General Services</b>	551,726	1,167,821	474,337	2,193,884	(1,889)	2,191,995	30,030	2,222,025		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			26,000	26,000		26,000		26,000		9
10	Nursing and Medical Records	4,988,570	505,191	53,130	5,546,891		5,546,891	117,995	5,664,886		10
10a	Therapy	25,879		12,779	38,658		38,658		38,658		10a
11	Activities	102,388	13,551		115,939		115,939		115,939		11
12	Social Services	315,363			315,363		315,363		315,363		12
13	CNA Training										13
14	Program Transportation			24,571	24,571		24,571	(3,804)	20,767		14
15	Other (specify):*							30,086	30,086		15
16	<b>TOTAL Health Care and Programs</b>	5,432,200	518,742	116,480	6,067,422		6,067,422	144,277	6,211,699		16
	<b>C. General Administration</b>										
17	Administrative	128,103		809,479	937,582		937,582	(754,273)	183,309		17
18	Directors Fees										18
19	Professional Services			554,660	554,660	(23,072)	531,588	46,864	578,452		19
20	Dues, Fees, Subscriptions & Promotions			92,160	92,160		92,160	(6,934)	85,226		20
21	Clerical & General Office Expenses	231,171	2,595	1,108,535	1,342,301		1,342,301	(612,146)	730,155		21
22	Employee Benefits & Payroll Taxes			1,387,463	1,387,463	1,889	1,389,352		1,389,352		22
23	Inservice Training & Education										23
24	Travel and Seminar			435	435		435	1,802	2,237		24
25	Other Admin. Staff Transportation			5,600	5,600		5,600	4,466	10,066		25
26	Insurance-Prop.Liab.Malpractice			546,430	546,430		546,430	23,792	570,222		26
27	Other (specify):*							69,536	69,536		27
28	<b>TOTAL General Administration</b>	359,274	2,595	4,504,762	4,866,631	(21,184)	4,845,447	(1,226,893)	3,618,554		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,343,200	1,689,158	5,095,579	13,127,937	(23,072)	13,104,865	(1,052,586)	12,052,278		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 & ID Number California Gardens N & Reh C

#0040022

Report Period Beginning:

01/01/16

Ending:

12/31/16

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			113,567	113,567		113,567	248,681	362,248			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,077	131,077		131,077	383,336	514,413			32
33	Real Estate Taxes					23,072	23,072	530,354	553,426			33
34	Rent-Facility & Grounds			1,510,667	1,510,667		1,510,667	(1,501,711)	8,956			34
35	Rent-Equipment & Vehicles			46,530	46,530		46,530	8,693	55,223			35
36	Other (specify):*							77,094	77,094			36
37	<b>TOTAL Ownership</b>			1,801,841	1,801,841	23,072	1,824,913	(253,553)	1,571,361			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		395,835	670,614	1,066,449		1,066,449	(14,080)	1,052,369			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			763,614	763,614		763,614		763,614			42
43	Other (specify):*	39,181		155,115	194,296		194,296	(194,296)	0			43
44	<b>TOTAL Special Cost Centers</b>	39,181	395,835	1,589,343	2,024,359		2,024,359	(208,376)	1,815,983			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,382,381	2,084,993	8,486,763	16,954,137		16,954,137	(1,514,514)	15,439,623			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	(13,617)	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	(86,488)	30		9
10	Interest and Other Investment Income	(15,862)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	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	(7,871)	21		18
19	Entertainment				19
20	Contributions	(12,950)	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	(664,987)	21		24
25	Fund Raising, Advertising and Promotional	(8,860)	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	(651,048)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,461,755)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(52,759)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (52,759)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,514,514)		37

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

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

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

**BHF USE ONLY**

48		49		50		51		52
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California Gardens N & Reh C

ID# 0040022

Report Period Beginning: 01/01/16

Ending: 12/31/16

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Sequestration Expense	\$ (329,906)	21	1
2	Veteran's Expense	(75,800)	10	2
3	Discounts Earned	(534)	21	3
4	Guest Relations	(39,181)	43	4
5	Bank Charges	(16,714)	21	5
6	Marketing Consultant	(147,287)	43	6
7	Marketing Services	(7,409)	43	7
8	Additional R&M	1,095	06	8
9	Building Co - Professional Fees	(11,970)	19	9
10	Building Co - Amortization	(5,712)	36	10
11	PAC Dues	(8,088)	20	11
12	Non Allowable Legal Fees	(9,124)	19	12
13	Intermedia Marketing	(419)	43	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				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>	(651,048)		49

California Gardens N & Reh C

Report Period Beginning:                     ID# 0040022                      
 Ending:   01/01/16                      
  12/31/16                    

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

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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	(72)											(72)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,617)		3,074									(10,543)	5
6	Maintenance	1,095		34,513									35,608	6
7	Other (specify):*			5,037									5,037	7
8	<b>TOTAL General Services</b>	<b>(12,594)</b>		<b>42,624</b>									<b>30,030</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(75,800)		193,795									117,995	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				(3,804)								(3,804)	14
15	Other (specify):*			30,086									30,086	15
16	<b>TOTAL Health Care and Programs</b>	<b>(75,800)</b>		<b>223,881</b>	<b>(3,804)</b>								<b>144,277</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(754,273)									(754,273)	17
18	Directors Fees													18
19	Professional Services	(21,094)	11,970	55,988									46,864	19
20	Fees, Subscriptions & Promotions	(29,898)		22,963									(6,934)	20
21	Clerical & General Office Expenses	(1,020,012)		407,866									(612,146)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,802									1,802	24
25	Other Admin. Staff Transportation			4,466									4,466	25
26	Insurance-Prop.Liab.Malpractice		18,570	5,222									23,792	26
27	Other (specify):*			69,536									69,536	27
28	<b>TOTAL General Administration</b>	<b>(1,071,004)</b>	<b>30,540</b>	<b>(186,430)</b>									<b>(1,226,893)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(1,159,398)</b>	<b>30,540</b>	<b>80,075</b>	<b>(3,804)</b>								<b>(1,052,586)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(86,488)	332,409	2,760									248,681	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(15,862)	399,198										383,336	32
33	Real Estate Taxes		523,492	6,862									530,354	33
34	Rent-Facility & Grounds		(1,510,667)	8,956									(1,501,711)	34
35	Rent-Equipment & Vehicles			8,693									8,693	35
36	Other (specify):*	(5,712)	82,806										77,094	36
37	<b>TOTAL Ownership</b>	<b>(108,062)</b>	<b>(172,762)</b>	<b>27,271</b>									<b>(253,553)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(14,080)							(14,080)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(194,296)											(194,296)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(194,296)</b>				<b>(14,080)</b>							<b>(208,376)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(1,461,755)</b>	<b>(142,222)</b>	<b>107,347</b>	<b>(3,804)</b>	<b>(14,080)</b>							<b>(1,514,514)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,510,667	California Gardens Associates	100.00%	\$	(1,510,667)	1
2	V	32 Interest	306	California Gardens Associates	100.00%	399,504	399,198	2
3	V	19 Accounting Fees		California Gardens Associates	100.00%	11,175	11,175	3
4	V	36 Amortization		California Gardens Associates	100.00%	5,712	5,712	4
5	V	19 Data Processing		California Gardens Associates	100.00%	524	524	5
6	V	30 Depreciation		California Gardens Associates	100.00%	332,409	332,409	6
7	V	26 Insurance Expense		California Gardens Associates	100.00%	18,570	18,570	7
8	V	36 Insurance - FHA Mortgage		California Gardens Associates	100.00%	77,094	77,094	8
9	V	19 Other Professional Fees		California Gardens Associates	100.00%	271	271	9
10	V	33 Real Estate Taxes		California Gardens Associates	100.00%	523,492	523,492	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,510,973			\$ 1,368,751	\$ * (142,222)	14

\* 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	5 UTILITIES	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 3,074	\$	3,074	15
16	V	6 MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	28,136		28,136	16
17	V	6 MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	6,376		6,376	17
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	5,037		5,037	18
19	V	10 CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	193,795		193,795	19
20	V	15 EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	30,086		30,086	20
21	V	17 ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	55,206		55,206	21
22	V	17 ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%				22
23	V	19 PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	55,988		55,988	23
24	V	20 DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	22,963		22,963	24
25	V	21 CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	362,702		362,702	25
26	V	21 CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	45,164		45,164	26
27	V	24 SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,802		1,802	27
28	V	25 TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	4,466		4,466	28
29	V	26 INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	5,222		5,222	29
30	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	69,536		69,536	30
31	V	30 DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,760		2,760	31
32	V	33 REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	6,862		6,862	32
33	V	34 BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	8,956		8,956	33
34	V	35 EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	3,872		3,872	34
35	V	35 AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	4,822		4,822	35
36	V								36
37	V	17 MANAGEMENT FEES	809,479	MAESTRO CONSULTING SERVICES LLC	100.00%			(809,479)	37
38	V								38
39	Total		\$ 809,479			\$ 916,826	\$ *	107,347	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	14 Transportation	\$ 28,845	Lifeline Ambulance		\$ 25,041	\$ (3,804)
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	<b>Total</b>		\$ 28,845			\$ 25,041	\$ * (3,804)

\* 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	\$ 138,988	Integra Healthcare Equipment		\$ 124,908	\$ (14,080)
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		\$ 138,988			\$ 124,908	\$ * (14,080)

\* 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	\$ 374,457	MAPLE LEAF INSURANCE	100.00%	\$ 374,457	\$	15
16	V	26 Liability Insurance	421,942	MAPLE LEAF INSURANCE	100.00%	421,942		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		\$ 796,399			\$ 796,399	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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





Facility Name & ID Number California Gardens N & Reh C # 0040022 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									\$		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:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	1,836,222	28	\$ 51,919	\$ 108,702	\$ 3,074	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	108,702	28,136	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711	108,702	6,376	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090	108,702	5,037	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	108,702	193,795	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220	108,702	30,086	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	108,702	55,206	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28		108,702		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768	108,702	55,988	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900	108,702	22,963	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	108,702	362,702	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920	108,702	45,164	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439	108,702	1,802	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434	108,702	4,466	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214	108,702	5,222	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614	108,702	69,536	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621	108,702	2,760	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912	108,702	6,862	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288	108,702	8,956	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399	108,702	3,872	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453	108,702	4,822	21
22									22
23									23
24									24
25	TOTALS					\$ 15,487,256	\$ 10,808,353	\$ 916,825	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	14	Transportation	Direct Allocation		\$	\$		\$ 25,041	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				\$	\$		\$ 25,041	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 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

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		\$	\$		\$ 124,908	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				\$	\$		\$ 124,908	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

Maple Leaf Insurance

Street Address

PO Box 69, 720 West Bay Rd

City / State / Zip Code

Grand Cayman, KY1-1102

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	22	Workers Compensation	Direct Allocation		\$	\$		\$ 374,457	1
2	26	Liability Insurance	Direct Allocation					421,942	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				\$	\$		\$ 796,399	25

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/16

Ending: 12/31/16

**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:

01/01/16

Ending: 12/31/16

**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:

01/01/16

Ending: 12/31/16

**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: 01/01/16 Ending: 12/31/16

**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:

01/01/16

Ending: 12/31/16

**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:

01/01/16

Ending:

12/31/16

**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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	HUD Loan		X	Mortgage			\$	\$ 13,891,938			\$	399,504						
2																		
3																		
4																		
5					-													
<b>Working Capital</b>																		
6	Private Bank		X	Note Payable								131,077						
7																		
8					-													
9	<b>TOTAL Facility Related</b>						\$	\$ 13,891,938			\$	530,581						
<b>B. Non-Facility Related*</b>																		
10	Interst Income		X									(15,862)						
11	Interest Income - Bldg. Co		X									(306)						
12																		
13					-													
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(16,167)						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 13,891,938			\$	514,414						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 77,094      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:

01/01/16

Ending:

12/31/16

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

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

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)





**IMPORTANT NOTICE**

**TO: Long Term Care Facilities with Real Estate Tax Rates**  
**RE: 2015 REAL ESTATE TAX COST DOCUMENTATION**

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME California Gardens N & Reh C COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0040022  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

**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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022 Report Period Beginning:

01/01/16 Ending:

12/31/16

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	193,025	1987	\$ 300,000	1
2	Allocated from Maestro Consulting/7257 Lincoln			9,472	2
3	TOTALS	193,025		\$ 309,472	3

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	\$ 332,409	35	\$ 176,340	\$ (156,069)	\$ 3,592,474	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1981	4,471		20			205	9
10	Various		1982	2,319		20				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			5,703	21
22	Various		1995	17,230		20			17,230	22
23	Various		1996	46,848		20	1,637	1,637	46,841	23
24	Various		1997	70,702		20	3,482	3,482	69,273	24
25	Various		1998	33,854		20	1,693	1,693	31,396	25
26	Various		1999	103,092		20	5,155	5,155	90,113	26
27	Various		2000	194,600		20	9,730	9,730	163,432	27
28	Various		2001	75,921		20	3,796	3,796	59,043	28
29	Various		2002	45,162		20	1,685	1,685	44,039	29
30	Various		2003	55,404		20	2,213	2,213	50,261	30
31	Various		2004	32,888		20	725	725	20,926	31
32	Various		2005	23,434		20	336	336	20,653	32
33	Various		2006	22,990		20	710	710	22,990	33
34	Various		2008	6,857		20	343	343	2,771	34
35	Various		2009	420,531		20	22,536	22,536	172,804	35
36	Various		2010	39,979		20	3,271	3,271	26,734	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	Various	2011	\$ 31,172	\$	20	\$ 2,737	\$ 2,737	\$ 19,822	37
38	Various	2012	18,660		20	1,866	1,866	8,125	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		648,765			30,064	30,064	327,162	67
68	Related Party Allocations (Pages 12H & 12I)		142,059	2,475		5,162	2,687	58,345	68
69	Financial Statement Depreciation			113,567			(113,567)		69
70	TOTAL (lines 4 thru 69)		\$ 6,889,393	\$ 448,451		\$ 273,480	\$ (174,971)	\$ 4,899,681	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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12A, Carried Forward</b>	\$ 6,889,393	\$ 448,451		\$ 273,480	\$ (174,971)	\$ 4,899,681	1	
2	Signs & Wiring On 1St Floor, Room 120	2013	2,720		20	136	136	544	2
3	Kitchen-Floor Drain & 8 Ft. Of Cast Iron Pipe	2013	4,200		20	210	210	735	3
4	Light Fixtures Under Front Of Building Canopy & Windows	2013	4,510		20	226	226	902	4
5	Framing/Drywall,Accoustical,Paint,Hvac-All Resident Bathrooms	2014	139,961		20	13,996	13,996	34,990	5
6	Injection Pump	2014	3,011		20	301	301	728	6
7	Fire Alarm Sprinkler System Work	2014	8,771		20	877	877	1,900	7
8	Conduit And Wire, Misc Pipe Fiting Fire Alarm	2014	2,852		20	285	285	642	8
9	Ran Rg 59/18 Cable To 12 Existing Cameras Located In The Ceilin	2014	8,200		20	820	820	1,777	9
10	Paging Amplifier And Cables	2015	2,570		20	367	367	520	10
11	Remove And Install New Base In 4 Hallways	2015	7,500		20	375	375	750	11
12	Install New Vinyl Base In All Patient Rooms	2015	19,500		20	975	975	1,950	12
13	Solar Shades, Cornice Boards & Installation For 3Rd Floor	2015	15,658		20	3,132	3,132	5,741	13
14	Hallway Remodeling - Painting & Flooring	2015	93,800		20	4,690	4,690	9,380	14
15	Paint/Flooring In Reception/Copier Area, Offices, Pantry Room	2015	169,530		20	8,477	8,477	14,834	15
16	--First Floor Entrance, Resident/Rehab Rooms Restrooms	2015			20				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	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,372,177	\$ 448,451		\$ 308,347	\$ (140,104)	\$ 4,975,074	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		\$ 7,372,177	\$ 448,451		\$ 308,347	\$ (140,104)	\$ 4,975,074	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		\$ 7,372,177	\$ 448,451		\$ 308,347	\$ (140,104)	\$ 4,975,074	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		\$ 7,372,177	\$ 448,451		\$ 308,347	\$ (140,104)	\$ 4,975,074	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)	\$ 7,372,177	\$ 448,451		\$ 308,347	\$ (140,104)	\$ 4,975,074	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		\$ 7,372,177	\$ 448,451		\$ 308,347	\$ (140,104)	\$ 4,975,074	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)	\$ 7,372,177	\$ 448,451		\$ 308,347	\$ (140,104)	\$ 4,975,074	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:

01/01/16

Ending:

12/31/16

## 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	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Various	2004	18,253		20	1,435	1,435	17,350	9
10	Various	2005	147,095		20			147,095	10
11	Interlocking Door Parts	2007	3,821		20	191	191	1,910	11
12	Clear Polish Wire Glass - 3 Rooms	2007	3,148		20	157	157	1,571	12
13	Clear Polish Wire Glass - 1 Room	2007	485		20	24	24	241	13
14	Cooling Tower	2007	36,990		20	1,850	1,850	18,499	14
15	2 Passenger Elevator	2007	6,721		20	336	336	3,360	15
16	Electrical Work	2007	17,065		20	853	853	8,531	16
17	Smoke Detectors and Standard Wire Bases	2007	3,509		20	175	175	1,751	17
18	Motor - Cooling Tower	2007	4,110		20	206	206	2,059	18
19	Tadiran IPx500 Telephone System	2008	21,467		20	2,147	2,147	19,323	19
20	Carpet; Armstrong Beckford	2008	7,103		20	355	355	3,195	20
21	Remote Annunciator Panel for Basement Generator	2008	3,852		20	193	193	1,737	21
22	Headend Installation and Home Run Wiring to Roof	2008	13,039		20	1,304	1,304	11,736	22
23	Change Heights of Outlets	2008	2,625		20	131	131	1,179	23
24	Video Monitoring System	2008	3,713		20	186	186	1,674	24
25	Outdoor Lighting	2008	8,415		20	421	421	3,789	25
26	CCTV to Monitor Floors	2008	3,469		20	173	173	1,557	26
27	Varieties of Burning Bushes	2008	8,175		20	409	409	3,681	27
28	Installation of Video Multiplexer Recorder	2008	2,710		20	136	136	1,224	28
29	Asphalt Paving Work	2008	4,350		20	218	218	1,962	29
30	Landscape Irrigation System	2008	18,000		20	900	900	8,100	30
31	New Elevator Door	2008	9,221		20	461	461	4,149	31
32	CABLE WIRING	2013	2,780		20	510	510	2,039	32
33	LAVATORY FAUCETS	2013	11,187		20	932	932	3,729	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 361,303	\$		\$ 13,703	\$ 13,703	\$ 271,441	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	<b>Totals from Page 12F, Carried Forward</b>		\$ 361,303	\$		\$ 13,703	\$ 13,703	\$ 271,441	1
2	WI-FI WIRING	2013	7,500		20	1,125	1,125	4,500	2
3	HOT WATER STORAGE TANK	2013	4,202		20	280	280	1,120	3
4	VOLTAGE OUTLETS FOR KIOSKS	2013	4,625		20	540	540	2,159	4
5	14 FIRE DAMPERS	2013	8,352		20	348	348	1,392	5
6	COMPRESSOR FOR WALK-IN FREEZER	2013	4,391		20	732	732	2,928	6
7	BLINDS, CABINETS, COUNTERTOPS, VINYL FLOORING	2013	3,910		20	782	782	3,128	7
8	RECOVERED AWNING	2013	2,665		20	244	244	977	8
9	SPRINKLER SYSTEM	2013	3,437		20	286	286	1,145	9
10	REPLACE BOILER	2013	8,758		20	219	219	876	10
11	60' CAST IRON PIPING	2013	12,000		20	300	300	1,200	11
12	RADIATOR RECORE	2013	3,720		20	310	310	1,240	12
13	SEWER CLEANOUT STATION	2013	9,800		20	327	327	1,307	13
14	Furnish and Install 19 2-hr Fire Dampers at floor to floor penetrations.	2013	19,600		20	1,143	1,143	4,573	14
15	Sprinkler System	2014	7,014		20	351	351	1,052	15
16	Flooring - Ceramic Tiles - 3rd & 4th Floor Shower/Tub Room	2014	10,987		20	549	549	1,648	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	3,143	18
19	3rd&4th FL Shower Room-Install Faucets, Grab Bars, Tiles	2014	28,800		20	1,440	1,440	4,320	19
20	Roof	2014	98,000		20	4,900	4,900	14,700	20
21	Parking Lot Paving	2014	28,750		20	1,438	1,438	4,313	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>		\$ 648,765	\$		\$ 30,064	\$ 30,064	\$ 327,162	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:

01/01/16

Ending:

12/31/16

## 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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Maestro Consulting/7257 Lincoln	2004	85,246	2,186	35	2,436	250	31,967	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Maestro Consulting Services	2003	693		20	35	35	455	9
10	Allocated from Maestro Consulting Services	2004	14,078		20	764	764	8,958	10
11	Allocated from Maestro Consulting Services	2005	835		20	42	42	495	11
12	Allocated from Maestro Consulting Services	2006	1,132		20	57	57	586	12
13	Allocated from Maestro Consulting Services	2008	1,193		20	60	60	493	13
14	Allocated from Maestro Consulting Services	2009	19,205		20	901	901	7,307	14
15	Allocated from Maestro Consulting Services	2010	2,951		20	148	148	960	15
16	Allocated from Maestro Consulting Services	2011	159		20	8	8	47	16
17	Allocated from Maestro Consulting Services	2012	178		20	9	9	42	17
18	Allocated from Maestro Consulting Services	2014	2,220		20	111	111	289	18
19	Allocated from Maestro Consulting Services	2015	624		20	31	31	42	19
20	Allocated from Maestro Consulting Services	2016	2,736	106	20	106		106	20
21									21
22	Allocated from Maestro Consulting/7257 Lincoln	2015	1,344	128	20	90	(38)	119	22
23	Allocated from Maestro Consulting/7257 Lincoln	2005	7,771	55	20	279	224	5,420	23
24	Allocated from Maestro Consulting/7257 Lincoln	2004	1,694		20	85	85	1,059	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)		\$ 142,059	\$ 2,475		\$ 5,162	\$ 2,687	\$ 58,345	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		\$ 142,059	\$ 2,475		\$ 5,162	\$ 2,687	\$ 58,345
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
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22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 142,059	\$ 2,475		\$ 5,162	\$ 2,687	\$ 58,345

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

Facility Name & ID Number California Gardens N & Reh C

# 0040022

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	\$ 637,977	\$	\$ 52,174	\$ 52,174	10	\$ 495,831	71
72	Current Year Purchases	10,960	286	1,422	1,136	10	1,469	72
73	Fully Depreciated Assets	847,817		201	201	10	879,963	73
74								74
75	TOTALS	\$ 1,496,754	\$ 286	\$ 53,797	\$ 53,511		\$ 1,377,263	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		Allocated from Maestro Consulti	2016	\$ 524	\$	\$ 105	\$ 105	5	\$ 524	76
77										77
78										78
79										79
80	TOTALS			\$ 524	\$	\$ 105	\$ 105		\$ 524	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)	\$ 9,178,927	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 448,737	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 362,249	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (86,488)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,352,861	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	C-I-P	\$ 60,020	92
93			93
94			94
95		\$ 60,020	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from Maestro Consulting</u>				<u>8,956</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>8,956</b>			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. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

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: \$ 42,014      Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>2012 Ford ParaTransit</u>	\$ <u>699</u>	\$ <u>8,388</u>	17
18	<u>Allocated from Maestro Consulting</u>			<u>4,822</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>699</b>	\$ <b>13,210</b>	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 249,639	\$		\$ 249,639	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			103,125			103,125	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			317,850			317,850	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				161,388		161,388	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>						234,447		234,447	13
14	<b>TOTAL</b>			\$		\$ 670,614	\$ 395,835		\$ 1,066,449	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.

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

As of **12/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,000	\$ 13,877	1
2	Cash-Patient Deposits	8,051	8,051	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	9,018,574	10,352,431	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		19,796	6
7	Other Prepaid Expenses	82,727	83,922	7
8	Accounts Receivable (owners or related parties)	3,038,026	3,142,637	8
9	Other(specify):		1,069,601	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 12,150,378	\$ 14,690,315	10
	<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	1,373,957	7,508,739	15
16	Equipment, at Historical Cost	1,372,933	2,338,214	16
17	Accumulated Depreciation (book methods)	(2,226,133)	(9,778,599)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		199,903	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,372)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	6,820	60,020	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 527,577	\$ 5,431,725	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 12,677,955	\$ 20,122,040	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 14,620,972	\$ 14,739,958	26
27	Officer's Accounts Payable		505,745	27
28	Accounts Payable-Patient Deposits	1,951	1,951	28
29	Short-Term Notes Payable		280,844	29
30	Accrued Salaries Payable	194,081	194,081	30
31	Accrued Taxes Payable (excluding real estate taxes)	92,248	92,248	31
32	Accrued Real Estate Taxes(Sch.IX-B)		492,600	32
33	Accrued Interest Payable		32,993	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	52,440	211,440	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 14,961,692	\$ 16,551,860	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,611,094	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>	\$	\$ 13,611,094	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 14,961,692	\$ 30,162,954	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,283,737)	\$ (10,040,914)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 12,677,955	\$ 20,122,040	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,203,541)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Bad Debt</b>	<b>(750,000)</b>	<b>3</b>
<b>4</b>	<b>Other Professional Fees</b>	<b>168,784</b>	<b>4</b>
<b>5</b>	<b>Hospital Insurance</b>	<b>161,517</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,623,240)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(660,497)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(660,497)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,283,737)</b>	<b>24</b> *

\* 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	\$ 15,980,839	1
2	Discounts and Allowances for all Levels	(159,049)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 15,821,790	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	418,423	6
7	Oxygen	887	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 419,310	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	21,092	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,542	19
20	Radiology and X-Ray	720	20
21	Other Medical Services	12,324	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 36,678	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15,862	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,862	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 16,293,640	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,193,884	31
32	Health Care	6,067,422	32
33	General Administration	4,866,631	33
<b>B. Capital Expense</b>			
34	Ownership	1,801,841	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,260,745	35
36	Provider Participation Fee	763,614	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 16,954,137	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(660,497)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (660,497)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,043,202	44
45	Private Pay - Net Inpatient Revenue	(833,569)	45
46	Medicare - Net Inpatient Revenue	1,256,662	46
47	Other-(specify) <b>Veteran</b>	514,923	47
48	Other-(specify) <b>Hospice, Managed Care</b>	4,840,572	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 15,821,790	49

\* 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:

01/01/16

Ending:

12/31/16

**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	1,988	2,172	\$ 132,227	\$ 60.88	1
2	Assistant Director of Nursing	1,955	2,159	96,520	44.71	2
3	Registered Nurses	33,495	36,614	1,195,083	32.64	3
4	Licensed Practical Nurses	67,723	74,546	2,026,914	27.19	4
5	CNAs & Orderlies	119,754	128,447	1,513,108	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,994	2,184	25,879	11.85	8
9	Activity Director	1,939	2,115	38,067	18.00	9
10	Activity Assistants	5,496	6,091	64,321	10.56	10
11	Social Service Workers	12,170	13,234	236,495	17.87	11
12	Dietician					12
13	Food Service Supervisor	1,982	2,263	67,903	30.01	13
14	Head Cook	5,104	5,834	109,262	18.73	14
15	Cook Helpers/Assistants	17,922	19,398	200,381	10.33	15
16	Dishwashers					16
17	Maintenance Workers	8,721	9,613	174,180	18.12	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,918	2,209	128,103	57.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,423	9,239	231,171	25.02	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	938	1,070	24,718	23.10	31
32	Other Health Care(specify)					32
33	Other(specify)	8,429	9,446	118,049	12.50	33
34	TOTAL (lines 1 - 33)	299,951	326,634	\$ 6,382,381 *	\$ 19.54	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	452	\$ 21,211	01-03	35
36	Medical Director	Monthly	26,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	5,328	10-03	38
39	Pharmacist Consultant	Monthly	47,802	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	213	12,779	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	665	\$ 113,120		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		
<u>Martin Lee</u>	<u>Administrator</u>	<u>0</u>	\$ <u>128,103</u>	<u>Workers' Compensation Insurance</u>	\$ <u>374,457</u>	<u>IDPH License Fee</u>	\$ _____		
				<u>Unemployment Compensation Insurance</u>	<u>91,736</u>	<u>Advertising: Employee Recruitment</u>			
				<u>FICA Taxes</u>	<u>460,009</u>	<u>Health Care Worker Background Check</u>	<u>6,111</u>		
				<u>Employee Health Insurance</u>	<u>392,060</u>	(Indicate # of checks performed <u>611.1</u> )			
				<u>Employee Meals</u>	<u>1,889</u>	<u>Patient Background Checks</u>	<u>5,035</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues &amp; Subscriptions</u>	<u>47,202</u>		
				<u>Pension Plan</u>	<u>50,678</u>	<u>Licenses &amp; Permits</u>	<u>3,914</u>		
				<u>Other Employee Benefits</u>	<u>7,974</u>	<u>Allocated from Maestro Consulting</u>	<u>22,963</u>		
				<u>Employees Physical Exams</u>	<u>10,549</u>				
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>128,103</u></b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>\$ <u>1,389,350</u></b>		
<b>(List each licensed administrator separately.)</b>				<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>			<b>\$ <u>85,224</u></b>		
<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	
<u>Management Fees - Maestro Consulting</u>			\$ <u>809,479</u>				<u>Out-of-State Travel</u>	\$ _____	
							<u>In-State Travel</u>		
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ <u>809,479</u></b>	<b>TOTAL</b>			<b>\$ _____</b>		
<b>(Attach a copy of any management service agreement)</b>				<b>(For legal fee disclosure, see page 39 of instructions)</b>					
<b>C. Professional Services</b>				<b>F. Dues, Fees, Subscriptions and Promotions</b>				<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
<u>Marcum LLP</u>	<u>Accounting Fees</u>	\$ <u>67,353</u>					<u>Seminar Expense</u>	<u>435</u>	
<u>Ability Network, Inc</u>	<u>Data Processing</u>	<u>7,989</u>					<u>Allocated from Maestro Consulting</u>	<u>1,802</u>	
<u>MTS Consulting</u>	<u>Consulting</u>	<u>6,133</u>							
<u>See Attached</u>	<u>Legal Fees</u>	<u>47,731</u>					<u>Entertainment Expense</u>	( _____ )	
<u>Care Cost</u>	<u>Cost Management</u>	<u>6,361</u>					<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>		
<u>Personnel Planners</u>	<u>Unemployment Consulting</u>	<u>2,031</u>					<b>\$ <u>2,237</u></b>		
<u>Corporation Services Company</u>	<u>Statutory Representation</u>	<u>627</u>							
<u>Health Dimensions Group</u>	<u>Valued Based PSA</u>	<u>1,076</u>							
<u>Maestro Consultants</u>	<u>Consulting</u>	<u>130,957</u>							
<u>Medical Business Office Services</u>	<u>Medical Billing/Coding</u>	<u>179,146</u>							
<u>HRM Consultants</u>	<u>Consulting</u>	<u>8,770</u>							
<u>See Supplemental Schedule</u>		<u>96,487</u>							

\* Attach copy of IMRF notifications

\*\*See instructions.

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

# 0040022

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC: \$24,508
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 763,614  
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 benefit on Schedule V. \$ 1,889 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 1  
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