

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0040022

Facility Name: California Gardens N & Reh C

Address: 2829 S Californ Blvd Chicago 60608
Number City Zip Code

County: Cook

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

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,798</u>	<u>2,798</u>	8
9	SNF/PED					9
10	ICF	<u>35,357</u>	<u>1,388</u>	<u>62,239</u>	<u>98,984</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,357</u>	<u>1,388</u>	<u>65,037</u>	<u>101,782</u>	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	
	A. General Services											
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	TOTAL General Services	551,726	1,167,821	474,337	2,193,884	(1,889)	2,191,995	30,030	2,222,025			8
	B. Health Care and Programs											
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	TOTAL Health Care and Programs	5,432,200	518,742	116,480	6,067,422		6,067,422	144,277	6,211,699			16
	C. General Administration											
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	TOTAL General Administration	359,274	2,595	4,504,762	4,866,631	(21,184)	4,845,447	(1,226,893)	3,618,554			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	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.

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	TOTAL Ownership			1,801,841	1,801,841	23,072	1,824,913	(253,553)	1,571,361			37
	Ancillary Expense											
	E. Special Cost Centers											
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	TOTAL Special Cost Centers	39,181	395,835	1,589,343	2,024,359		2,024,359	(208,376)	1,815,983			44
45	GRAND TOTAL COST (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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,461,755)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(52,759)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (52,759)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

0040022

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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	Total	(651,048)		49

ID#

0040022

Report Period Beginning:

01/01/16

Ending:

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	Total			49

Summary A

12/31/16

[illegible]

Summary B

12/31/16

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	TOTAL Ownership	(108,062)	(172,762)	27,271									(253,553)	37
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	(194,296)				(14,080)							(208,376)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,461,755)	(142,222)	107,347	(3,804)	(14,080)							(1,514,514)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	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.

☒ X

 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%			
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)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 28,845			\$ 25,041	\$ * (3,804)	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	39	DME & Medical Supplies	\$ 138,988	Integra Healthcare Equipment		\$ 124,908	\$ (14,080)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 138,988			\$ 124,908	\$ * (14,080)	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	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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARRY & RANDY CARR	4.750%	MAPLECREST CARE CENTRE	BELVIDERE	MAESTRO CONSULTING SERV	LINCOLNWOOD	MANAGEMENT	1
2	FAIRHOME TRUST U/A/D 12/31/12	25.000%	MCKINLEY COURT	DECATUR	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	2
3	GERRY JENICH	5.000%	MONROE PAVILION	CHICAGO	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY/WORK COMP IN	3
4	RAJCHENBACH FAMILY TRUST	4.750%	NORTHWOODS CARE CENTRE	BELVIDERE	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	4
5	ROBERT HARTMAN	55.750%	SYCAMORE VILLAGE	SWANSEA	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERVICES	5
6	MARK HOLLANDER DISCRETIONARY TRUST	1.583%	SYMPHONY ARIA	HILLSIDE	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	6
7	SHARON HOLLANDER DISCRETIONARY TRUST	1.583%	SYMPHONY AT 87TH STREET	CHICAGO	CALIFORNIA GARDENS ASSOC	CHICAGO	BUILDING COMPANY	7
8	FEIGE C. KNOBEL DISCRETIONARY TRUST	1.584%	SYMPHONY AT MIDWAY	CHICAGO				8
9			SYMPHONY AT THE TILLERS	OSWEGO				9
10			SYMPHONY OF BRONZEVILLE	CHICAGO				10
11			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				11
12			SYMPHONY OF CHESTERTON	CHESTERTON, IN				12
13			SYMPHONY OF CHICAGO WEST	CHICAGO				13
14			SYMPHONY OF CRESTWOOD	CRESTWOOD				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, IN				15
16			SYMPHONY OF DECATUR	DECATUR				16
17			SYMPHONY OF DYER	DYER, IN				17
18			SYMPHONY OF EVANSTON	EVANSTON				18
19			SYMPHONY OF GLENDALE	GLENDALE, WI				19
20			SYMPHONY OF HANOVER PARK	HANOVER PARK				20
21			SYMPHONY OF JOLIET	JOLIET				21
22			SYMPHONY OF LINCOLN	LINCOLN				22
23			SYMPHONY OF LINCOLN PARK	CHICAGO				23
24			SYMPHONY OF MORGAN PARK	CHICAGO				24
25			SYMPHONY OF ORCHARD VALLEY	AURORA				25
26			SYMPHONY OF SOUTH SHORE	CHICAGO				26
27			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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

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

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

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

Facility Name & ID Number California Gardens N & Reh C # 0040022 Report Period Beginning: 01/01/16 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,836,222	28	\$ 51,919	\$	108,702	\$ 3,074	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	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	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	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	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

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

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

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

()

()

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

Facility Name & ID Number California Gardens N & Reh C # 0040022 Report Period Beginning: 01/01/16 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	TOTALS					\$	\$		\$	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	TOTALS					\$	\$		\$	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	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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.)

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

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

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

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

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.)

B. Real Estate Taxes

NOTES:

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

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

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.

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.

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.

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.

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

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.

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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.)

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.

	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

Facility Name & ID Number California Gardens N & 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		
	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			222	10	
11	Various			1983	10,829		20			1,580	11	
12	Various			1984	1,410		20			277	12	
13	Various			1985	17,805		20			492	13	
14	Various			1986	22,863		20			6,764	14	
15	Various			1987	40,100		20			13,868	15	
16	Various			1988	2,787		20			2,787	16	
17	Various			1989	3,024		20			1,348	17	
18	Various			1990	8,652		20			4,290	18	
19	Various			1991	3,892		20			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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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.

Facility Name & ID Number California Gardens N & 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	Totals from Page 12A, Carried Forward		\$ 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	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	Totals from Page 12B, Carried Forward		\$ 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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 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	Totals from Page 12D, Carried Forward		\$ 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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 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 & ID Number California Gardens N & 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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	18,253		20	1,435	1,435	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	TOTAL (lines 1 thru 33)		\$ 361,303	\$		\$ 13,703	\$ 13,703	\$ 271,441	34

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 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	TOTAL (lines 1 thru 33)		\$ 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 & ID Number California Gardens N & 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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 142,059	\$ 2,475		\$ 5,162	\$ 2,687	\$ 58,345	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)		\$ 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)

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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$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	Allocated from Maestro Consulting				8,956			5
6								6
7	TOTAL				\$ 8,956			7

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 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	Facility	2012 Ford ParaTransit	\$ 699	\$ 8,388	17
18	Allocated from Maestro Consulting			4,822	18
19					19
20					20
21	TOTAL		\$ 699	\$ 13,210	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent

12. /2017 \$

13. /2018 \$

14. /2019 \$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	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
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						234,447		234,447	13
14	TOTAL			\$		\$ 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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,150,378	\$ 14,690,315	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,151,920	13
14	Buildings, at Historical Cost		3,973,900	14
15	Leasehold Improvements, at Historical Cost	1,373,957	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 527,577	\$ 5,431,725	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,677,955	\$ 20,122,040	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
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
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	52,440	211,440	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 14,961,692	\$ 16,551,860	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,611,094	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 13,611,094	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,961,692	\$ 30,162,954	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,283,737)	\$ (10,040,914)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,677,955	\$ 20,122,040	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

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

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

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,193,884	31
32	Health Care	6,067,422	32
33	General Administration	4,866,631	33
	B. Capital Expense		
34	Ownership	1,801,841	34
	C. Ancillary Expense		
35	Special Cost Centers	1,260,745	35
36	Provider Participation Fee	763,614	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,954,137	40
41	Income before Income Taxes (line 30 minus line 40)**	(660,497)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (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) Veteran	514,923	47
48	Other-(specify) Hospice, Managed Care	4,840,572	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 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.

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

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

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

** See instructions.

Facility Name & ID Number		California Gardens N & Reh C		STATE OF ILLINOIS	#	0040022	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>ICLTC: \$24,508</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>N/A</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>763,614</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>Yes</u>							
(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? 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.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ <u>1,889</u> <u>N/A</u> Indicate the amount. \$							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>N/A</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% Ln 1</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(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. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							