

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	108,405	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	108,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF			1,576	1,576	8
9	SNF/PED					9
10	ICF	52,918	400	48,349	101,667	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,918	400	49,925	103,243	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.24%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 1,576

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number California Gardens Nursing & Rehab Center # 0040022 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	402,062	51,388	21,464	474,914		474,914	-	474,914		1
2	Food Purchase		529,348		529,348		529,348	-	529,348		2
3	Housekeeping	24,076	429,330	-	453,406		453,406	-	453,406		3
4	Laundry	-	229,559	3,345	232,904		232,904	-	232,904		4
5	Heat and Other Utilities			236,171	236,171		236,171	3,141	239,312		5
6	Maintenance	212,182	-	154,823	367,005		367,005	11,456	378,461		6
7	Other (specify):*	-	-	-				-			7
8	TOTAL General Services	638,320	1,239,625	415,803	2,293,748		2,293,748	14,597	2,308,345		8
	B. Health Care and Programs										
9	Medical Director	-	-	36,000	36,000		36,000	-	36,000		9
10	Nursing and Medical Records	5,186,251	252,243	54,315	5,492,809		5,492,809	9,204	5,502,013		10
10a	Therapy	-	-	-				-			10a
11	Activities	200,371	-	2,159	202,530		202,530	-	202,530		11
12	Social Services	224,586	-	-	224,586		224,586	-	224,586		12
13	CNA Training	-	-	-				-			13
14	Program Transportation	-	-	-				-			14
15	Other (specify):* Mgmt Alloc of Benefit	-	-	-				65,291	65,291		15
16	TOTAL Health Care and Programs	5,611,208	252,243	92,474	5,955,925		5,955,925	74,495	6,030,420		16
	C. General Administration										
17	Administrative	158,793	-	830,189	988,982		988,982	(830,189)	158,793		17
18	Directors Fees			-				-			18
19	Professional Services			609,124	609,124		609,124	147,513	756,637		19
20	Dues, Fees, Subscriptions & Promotions			64,936	64,936		64,936	(11,702)	53,234		20
21	Clerical & General Office Expenses	140,799	15,255	47,138	203,192		203,192	365,304	568,496		21
22	Employee Benefits & Payroll Taxes			944,319	944,319		944,319	2,605	946,924		22
23	Inservice Training & Education			-				-			23
24	Travel and Seminar			5,585	5,585		5,585	(1,072)	4,513		24
25	Other Admin. Staff Transportation		-	2,527	2,527		2,527	11,661	14,188		25
26	Insurance-Prop.Liab.Malpractice			1,107,139	1,107,139		1,107,139	21,240	1,128,379		26
27	Other (specify):* Mgmt Alloc of Benefit	-	-	-				32,572	32,572		27
28	TOTAL General Administration	299,592	15,255	3,610,957	3,925,804		3,925,804	(262,068)	3,663,736		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,549,120	1,507,123	4,119,234	12,175,477		12,175,477	(172,976)	12,002,501		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)

Table with columns: Capital Expense, Cost Per General Ledger (Salary/Wage, Supplies, Other, Total), Reclassification, Reclassified Total, Adjustments, Adjusted Total, FOR BHF USE ONLY (9, 10). Rows include D. Ownership (30-37), Ancillary Expense, E. Special Cost Centers (38-44), and GRAND TOTAL COST (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	(22,509)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(83,186)	30		9
10	Interest and Other Investment Income	(16,128)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	7,543	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,832)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(381,334)	43		24
25	Fund Raising, Advertising and Promotional				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 See PG5A	(284,297)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (784,743)		\$	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	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)	(374,506)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (374,506)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,159,249)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

California Gardens Nursing & Rehab Center

ID# 0040022

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (159,696)	43	1
2	Laboratory Costs	(19,011)	43	2
3	X-Ray Costs	(8,656)	43	3
4	Theft and Damage Loss	(180)	43	4
5	Admissions	(71,708)	43	5
6	Chamber of commerce dues	(19,305)	20	6
7	Radiology Costs	(2,230)	43	7
8	Misc. Income	(902)	21	8
9	Replacement Tax	(5,000)	43	9
10	Leasehold Improvement less than \$2,500	2,466	6	10
11	Nonallowable legal	(75)	19	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				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	(284,297)		49

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	19 Accounting Fees - Admin	\$	California Gardens Associates	100%	\$ 17,064	\$ 17,064	1
2	V	26 Insurance Expense		California Gardens Associates	100%	15,398	15,398	2
3	V	30 Depreciation		California Gardens Associates	100%	303,185	303,185	3
4	V	32 Interest	430	California Gardens Associates	100%	383,477	383,047	4
5	V	33 Real Estate Taxes		California Gardens Associates	100%	591,502	591,502	5
6	V	34 Rental Income	1,614,562	California Gardens Associates	100%		(1,614,562)	6
7	V	36 MIP Insurance		California Gardens Associates	100%	74,000	74,000	7
8	V	36 Amortization		California Gardens Associates	100%	5,712	5,712	8
9	V	43 Replacement Tax		California Gardens Associates	100%	5,000	5,000	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,614,992			\$ 1,395,338	\$ * (219,654)	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%	\$ 3,141	\$ 3,141	15
16	V	6 MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100%			16
17	V	6 MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100%	8,990	8,990	17
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100%			18
19	V	10 CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100%	203,027	203,027	19
20	V	10 CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100%	10,080	10,080	20
21	V	15 EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100%	65,291	65,291	21
22	V	17 ADMINISTRATIVE MANAGEMENT FEI	830,189	MAESTRO CONSULTING SERVICES LLC	100%		(830,189)	22
23	V	19 PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100%	130,524	130,524	23
24	V	20 DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100%	7,603	7,603	24
25	V	21 CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100%	101,284	101,284	25
26	V	21 CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100%	61,895	61,895	26
27	V	24 SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100%	1,533	1,533	27
28	V	25 TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100%	11,661	11,661	28
29	V	26 INSURANCE		MAESTRO CONSULTING SERVICES LLC	100%	5,843	5,843	29
30	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100%	32,572	32,572	30
31	V	30 DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100%	22,502	22,502	31
32	V	32 INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100%	96	96	32
33	V	33 REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100%	5,910	5,910	33
34	V	34 BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100%	4,294	4,294	34
35	V	35 EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100%	10,633	10,633	35
36	V	35 AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100%	9,457	9,457	36
37	V							37
38	V							38
39	Total		\$ 830,189			\$ 696,336	\$ * (133,853)	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	38	Transportation	\$ 20,554	Lifeline Ambulance	100%	\$ 18,603	\$ (1,951)	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			\$ 20,554			\$ 18,603	\$ * (1,951)	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	10	Nursing Supplies	\$ 5,642	Integra Healthcare Equipment	100%	\$ 4,766	\$ (876)	15
16	V	35	Equipment Rental	76,666	Integra Healthcare Equipment	100%	64,760	(11,906)	16
17	V	39	Oxygen Supplies	30,573	Integra Healthcare Equipment	100%	25,825	(4,748)	17
18	V	39	Respiratory Consultant	8,852	Integra Healthcare Equipment	100%	7,477	(1,375)	18
19	V	43	Penalties	920	Integra Healthcare Equipment	100%	777	(143)	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			\$ 122,653			\$ 103,605	\$ * (19,048)	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	\$ 186,446	MAPLE LEAF INSURANCE	100%	\$ 186,446	\$	15
16	V	26	Liability Insurance	674,810	MAPLE LEAF INSURANCE	100%	674,810		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			\$ 861,256			\$ 861,256	\$ *	39

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

Facility Name & ID Number

California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	4.75%	MAPLECREST CARE CENTRE	BELVIDERE	MAESTRO CONSUL	LINCOLNWOOD	MANAGEMENT	1
2	FAIRHOME TRUST U/A/D 12/31/12	25.00%	MONROE PAVILION	CHICAGO	7257 N. LINCOLN AV	LINCOLNWOOD	BUILDING RENTA	2
3	GERRY JENICH	5.00%	NORTHWOODS CARE CENTRE	BELVIDERE	MAPLELEAF INSUR	GRAND CAYMAN	LIABILITY/WORK	3
4	RAJCHENBACH FAMILY TRUST	4.75%	SYCAMORE VILLAGE	SWANSEA	INTEGRA HEALTHC	ELMHURST	DME & MEDICAL	4
5	ROBERT HARTMAN	55.75%	SYMPHONY ARIA	HILLSIDE	INTEGRA RESPIRA	ELMHURST	RESPIRATORY SE	5
6	MARK HOLLANDER DISCRETIONARY	1.58%	SYMPHONY AT 87TH STREET	CHICAGO	LIFELINE AMBULA	CHICAGO	AMBULANCE	6
7	SHARON HOLLANDER DISCRETIONA	1.58%	SYMPHONY AT MIDWAY	CHICAGO	CALIFORNIA GARD	CHICAGO	BUILDING COMP.	7
8	FEIGE C. KNOBEL DISCRETIONARY T	1.58%	SYMPHONY AT THE TILLERS	OSWEGO				8
9			SYMPHONY OF BRONZEVILLE	CHICAGO				9
10			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				10
11			SYMPHONY OF CHESTERTON	CHESTERTON, IN				11
12			SYMPHONY OF CHICAGO WEST	CHICAGO				12
13			SYMPHONY OF CRESTWOOD	CRESTWOOD				13
14			SYMPHONY OF CROWN POINT	CROWN POINT, IN				14
15								15
16			SYMPHONY OF DYER	DYER, IN				16
17			SYMPHONY OF EVANSTON	EVANSTON				17
18			SYMPHONY OF GLENDALE	GLENDALE, WI				18
19			SYMPHONY OF HANOVER PARK	HANOVER PARK				19
20			SYMPHONY OF JOLIET	JOLIET				20
21								21
22			SYMPHONY OF LINCOLN PARK	CHICAGO				22
23			SYMPHONY OF MORGAN PARK	CHICAGO				23
24			SYMPHONY OF ORCHARD VALLEY	AURORA				24
25			SYMPHONY OF SOUTH SHORE	CHICAGO				25
26			SYMPHONY RESIDENCES OF LINCOLN PA	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number California Gardens Nursing & Rehab Center # 0040022 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	No owners receive compensation from this facility								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	1,668,541	25	\$ 48,352	\$ 108,405	\$ 3,141	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,668,541	25		108,405		2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,668,541	25	138,375	108,405	8,990	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,668,541	25		108,405		4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,668,541	25	3,124,933	3,124,933	203,027	5
6	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,668,541	25	155,149	108,405	10,080	6
7	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,668,541	25	1,004,938	108,405	65,291	7
8	17	ADMINISTRATIVE MANAGEM	AVAIL. CENSUS DAYS	1,668,541	25		108,405		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,668,541	25	2,008,992	108,405	130,524	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,668,541	25	117,020	108,405	7,603	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,668,541	25	1,558,938	1,558,938	101,284	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,668,541	25	952,676	108,405	61,895	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,668,541	25	23,599	108,405	1,533	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,668,541	25	179,481	108,405	11,661	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,668,541	25	89,939	108,405	5,843	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,668,541	25	501,334	108,405	32,572	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,668,541	25	346,345	108,405	22,502	17
18	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,668,541	25	1,470	108,405	96	18
19	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,668,541	25	90,970	108,405	5,910	19
20	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,668,541	25	66,085	108,405	4,294	20
21	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,668,541	25	163,656	108,405	10,633	21
22	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,668,541	25	145,555	108,405	9,457	22
23									23
24									24
25	TOTALS				\$ 10,717,807	\$ 4,683,871		\$ 696,336	25

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	38	Transportation	Direct Allocation		\$	\$		\$ 18,603	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				\$	\$		\$ 18,603	25

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	10	Nursing Supplies	Direct Allocation		\$	\$		\$ 4,766	1
2	35	Equipment rental	Direct Allocation					64,760	2
3	39	Oxygen Supplies	Direct Allocation					25,825	3
4	39	Respiratory Consultant	Direct Allocation					7,477	4
5	43	Penalties	Direct Allocation					777	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				\$	\$		\$ 103,605	25

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending: 12/31/18

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		\$	\$		\$ 186,446	1
2	26	Liability Insurance	Direct Allocation					674,810	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				\$	\$		\$ 861,256	25

Facility Name & ID Number California Gardens Nursing & Rehab Center # 0040022 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	LifeMed	X		Pharmacy Services	38,731.00	1/1/2018	\$ 6,197,033	\$ 197,630	1/1/2024	0.075	\$ 12,639	1								
2	Omnicare		X	Pharmacy Services	67,444.34	11/27/2017	2,170,337	33,115	10/20/2020	0.075	3,489	2								
3	HUD Loan		X	Mortgage	Varies	1/30/2013	14,897,400	13,322,141	2/1/2048	0.0285	389,189	3								
4												4								
5												5								
Working Capital																				
6	Midcap Financial Trust*		X	Line of Credit (Revolving)	Interest	9/18/2018	35,000,000		9/17/2021	LIBOR + 4.25'		6								
7	* Original loan with Symcare Healthcare LLC. Facility pays the interest expense																			
8												8								
9	TOTAL Facility Related				\$106,175.34		\$ 58,264,770	\$ 13,552,886			\$ 405,317	9								
B. Non-Facility Related*																				
10												10								
11											(16,558)	11								
12											96	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (16,462)	14								
15	TOTALS (line 9+line14)						\$ 58,264,770	\$ 13,552,886			\$ 388,855	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 74,000 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 (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.

2017

\$ **538,489** 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ **551,200** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **12,711** 3

4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **578,791** 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

Alloc Fr. Mgmt Co. **5,910**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **597,412** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	409,218	8
	2014	417,462	9
	2015	469,203	10
	2016	512,841	11
	2017	551,200	12

2018 Accrual: \$551,200 x 1.05 = \$578,760. Use 578,791.

Allocated from Maestro Consulting Services \$5,910

Beginning Accrual Adjusted

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 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 Ari Krupp

TELEPHONE (410) 258-7363 FAX #: N/A

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-25-401-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>551,200.00</u>	\$ <u>551,200.00</u>
2. <u>10-27-319-028-0000</u>	<u>Allocated from Maestro Consulting</u>	\$ <u>87,874.67</u>	\$ <u>5,910.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>639,074.67</u>	\$ <u>557,110.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

none

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	193,025	1987	\$ 300,000	1
2	Allocated from Maestro Consulting/7257 Lincoln			10,395	2
3	TOTALS	193,025		\$ 310,395	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	\$	35	\$ 176,340	\$ 176,340	\$ 3,945,154	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	-		46,841	23
24	Various			1997	70,702		20	7	7	70,702	24
25	Various			1998	33,854	-	20	767	767	33,854	25
26	Various			1999	103,092	-	20	5,155	5,155	100,422	26
27	Various			2000	194,600	-	20	9,730	9,730	182,892	27
28	Various			2001	75,921		20	3,796	3,796	66,635	28
29	Various			2002	45,162		20			45,162	29
30	Various			2003	55,404		20	2,213	2,213	54,686	30
31	Various			2004	32,888		20	725	725	22,376	31
32	Various			2005	23,434		20	336	336	21,325	32
33	Various			2006	22,990		20			22,990	33
34	Various			2008	6,857		20	343	343	3,457	34
35	Various			2009	420,531		20	22,539	22,539	217,882	35
36	Various			2010	39,979	-	20	3,271		33,276	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

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	
37	Various	2011	\$ 31,172	\$ -	20	\$ 2,283	\$ 2,283	\$ 24,388	37
38	Various	2012	18,660	-	20	1,866	1,866	11,857	38
39	Various	2013	11,430	-	20	572	572	3,325	39
40	Framing & Drywall, Accoustical, Paint, Hvac For All Resident Ba	2014	139,961	-	20	13,996	13,996	62,982	40
41	Injection Pump	2014	3,011	-	20	301	301	1,330	41
42	Fire Alarm Sprinkler System Work	2014	8,771	-	20	877	877	3,655	42
43	Conduit And Wire, Misc Pipe Fiting Fire Alarm	2014	2,852	-	20	285	285	1,212	43
44	Ran Rg 59/18 Cable To 12 Existing Cameras Located In The Ceili	2014	8,200	-	20	820	820	3,417	44
45	Paging Amplifier And Cables	2015	2,570	-	20	367	367	1,254	45
46	Remove And Install New Base In 4 Hallways	2015	7,500	-	20	375	375	1,500	46
47	Install New Vinyl Base In All Patient Rooms	2015	19,500	-	20	975	975	3,900	47
48	Solar Shades, Cornice Boards & Installation For 3Rd Floor	2015	15,658	-	20	3,132	3,132	12,004	48
49	Hallway Remodeling - Painting & Flooring	2015	93,800	-	20	4,690	4,690	18,760	49
50	Paint/Flooring/Fixtures Throughout Building	2015	169,530	-	20	8,477	8,477	31,787	50
51	Nexus Comm Phone System	2017	22,474	-	20	1,124	1,124	2,060	51
52	Top Notch Boiler Replacement	2017	7,730	-	20	387	387	645	52
53	Rescor New Pump	2017	3,244	-	20	162	162	216	53
54	Replace Circulating Pump	2017	3,465	-	20	173	173	289	54
55	Phone System Upgrade	2017	32,175	-	20	1,609	1,609	2,816	55
56	Galvanized Steel Insulated Door	2017	4,156	-	20	208	208	277	56
57	Galvanized Hollow metal frame and steel door-Laundry Room Lo	2018	6,015	221	20	221	-	221	57
58	Steel Insulated Door-Galvanized - Medical Waste Lower Level	2018	2,632	87	20	87	-	87	58
59	Replace OS&Y Globe Vaves-Sprinkler System Lower Level	2018	3,065	19	20	19	-	19	59
60	Chiller Pump & Coil Replacement-Chiller Room Lower Level	2018	248,984	11,889	20	11,889	-	11,889	60
61									61
62	Leasehold Improvements:								62
63	Various	2004	18,253	-	20	-	-	18,253	63
64	Various	2005	147,095	-	20	-	-	147,095	64
65	Interlocking Door Parts	2007	3,821	-	20	191	191	2,101	65
66	Clear Polish Wire Glass - 3 Rooms	2007	3,148	-	20	157	157	1,728	66
67	Clear Polish Wire Glass - 1 Room	2007	485	-	20	24	24	265	67
68	Cooling Tower	2007	36,990	-	20	1,850	1,850	20,349	68
69	2 Passenger Elevator	2007	6,721	-	20	336	336	3,696	69
70	TOTAL (lines 4 thru 69)		\$ 7,131,806	\$ 12,216		\$ 282,675	\$ 267,188	\$ 5,333,510	70

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

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		\$ 7,131,806	\$ 12,216		\$ 282,675	\$ 270,459	\$ 5,333,510	1
2	Electrical Work	2007	17,065		20	853	853	10,237	2
3	Smoke Detectors and Standard Wire Bases	2007	3,509		20	175	175	2,101	3
4	Motor - Cooling Tower	2007	4,110		20	206	206	2,471	4
5	Tadiran IPx500 Telephone System	2008	21,467		20	2,144	2,144	21,467	5
6	Carpet; Armstrong Beckford	2008	7,103		20	355	355	3,905	6
7	Remote Annunciator Panel for Basment Generator	2008	3,852		20	193	193	2,123	7
8	Headend Installation and Home Run Wiring to Roof	2008	13,039		20	1,303	1,303	13,039	8
9	Change Heights of Outlets	2008	2,625		20	131	131	1,441	9
10	Video Monitoring System	2008	3,713		20	186	186	2,046	10
11	Outdoor Lighting	2008	8,415		20	421	421	4,631	11
12	CCTV to Monitor Floors	2008	3,469		20	173	173	1,903	12
13	Varieties of Burning Bushes	2008	8,175		20	409	409	4,499	13
14	Installation of Video Multiplexer Recorder	2008	2,710		20	136	136	1,496	14
15	Asphalt Paving Work	2008	4,350		20	218	218	2,398	15
16	Landscape Irrigation System	2008	18,000		20	900	900	9,900	16
17	New Elevator Door	2008	9,221		20	461	461	5,071	17
18	CABLE WIRING	2013	2,780		20	510	510	2,780	18
19	LAVATORY FAUCETS	2013	11,187		20	932	932	5,593	19
20	WI-FI WIRING	2013	7,500		20	1,125	1,125	5,625	20
21	HOT WATER STORAGE TANK	2013	4,202		20	280	280	1,400	21
22	VOLTAGE OUTLETS FOR KIOSKS	2013	4,625		20	540	540	2,699	22
23	14 FIRE DAMPERS	2013	8,352		20	348	348	1,740	23
24	COMPRESSOR FOR WALK-IN FREEZER	2013	4,391		20	732	732	3,660	24
25	BLINDS, CABINETS, COUNTERTOPS, VINYL FLOORING	2013	3,910		20	782	782	3,910	25
26	RECOVERED AWNING	2013	2,665		20	244	244	1,221	26
27	SPRINKLER SYSTEM	2013	3,437		20	286	286	1,431	27
28	REPLACE BOILER	2013	8,758		20	219	219	1,095	28
29	60' CAST IRON PIPING	2013	12,000		20	300	300	1,500	29
30	RADIATOR RECORE	2013	3,720		20	310	310	1,550	30
31	SEWER CLEANOUT STATION	2013	9,800		20	327	327	1,634	31
32	Furnish and Install 19 2-hr Fire Dampers at floor to floor penetrat	2013	19,600		20	1,143	1,143	5,716	32
33	Sprinkler System	2014	7,014		20	351	351	1,403	33
34	TOTAL (lines 1 thru 33)		\$ 7,376,570	\$ 12,216		\$ 299,368	\$ 287,152	\$ 5,465,195	34

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

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 7,376,570	\$ 12,216		\$ 299,368	\$ 287,152	\$ 5,465,195	1	
2	Flooring - Ceramic Tiles - 3rd & 4th Floor Shower/Tub Room	2014 10,987		20	549	549	2,197	2	
3	3 Elevators-Install Door Restrictors, Emergency Phones,			20				3	
4	Code Data Plates, Emergency Light Battery, Alarm Bells	2014 20,951		20	1,048	1,048	4,191	4	
5	3rd&4th FL Shower Room-Install Faucets, Grab Bars, Tiles	2014 28,800		20	1,440	1,440	5,760	5	
6	Roof	2014 98,000		20	4,900	4,900	19,600	6	
7	Parking Lot Paving	2014 28,750		20	1,438	1,438	5,751	7	
8					-			8	
9	Tie depreciation to financials		70,585			(70,585)		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)	\$ 7,564,058	\$ 82,801		\$ 308,743	\$ 225,942	\$ 5,502,694	34	

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

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning:

01/01/18

Ending:

12/31/18

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 12C, Carried Forward		\$ 7,564,058	\$ 82,801		\$ 308,743	\$ 225,942	\$ 5,502,694	1
2	Buildings:			-		-			2
3	<u>Allocated from Maestro Consulting Services/7257 Lincoln</u>	2004	93,557		35	2,673	2,673	40,430	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated from Maestro Consulting Services</u>	2003	762		20	38	38	575	9
10	<u>Allocated from Maestro Consulting Services</u>	2004	15,450		20	771	771	11,373	10
11	<u>Allocated from Maestro Consulting Services</u>	2005	916		20	46	46	635	11
12	<u>Allocated from Maestro Consulting Services</u>	2006	1,242		20	62	62	768	12
13	<u>Allocated from Maestro Consulting Services</u>	2008	1,309		20	65	65	671	13
14	<u>Allocated from Maestro Consulting Services</u>	2009	21,078		20	1,054	1,054	10,128	14
15	<u>Allocated from Maestro Consulting Services</u>	2010	3,239		20	162	162	1,378	15
16	<u>Allocated from Maestro Consulting Services</u>	2011	175		20	9	9	69	16
17	<u>Allocated from Maestro Consulting Services</u>	2012	195		20	10	10	66	17
18	<u>Allocated from Maestro Consulting Services</u>	2014	2,436		20	122	122	561	18
19	<u>Allocated from Maestro Consulting Services</u>	2015	685		20	34	34	114	19
20	<u>Allocated from Maestro Consulting Services</u>	2016	3,002		20	300	300	717	20
21	<u>Allocated from Maestro Consulting Services</u>	2017	401		20	20	20	40	21
22	<u>Allocated from Maestro Consulting Services/7257 Lincoln</u>	2004	1,859		20	93	93	1,348	22
23	<u>Allocated from Maestro Consulting Services/7257 Lincoln</u>	2005	8,529		20	306	306	6,560	23
24	<u>Allocated from Maestro Consulting Services/7257 Lincoln</u>	2015	1,475		20	98	98	328	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)		\$ 7,720,368	\$ 82,801		\$ 314,606	\$ 231,805	\$ 5,578,455	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	\$ 471,552	\$ 43,992	\$ 36,894	\$ (7,098)	10	\$ 403,258	71
72	Current Year Purchases	25,759	4,029	4,029	-	10	4,029	72
73	Fully Depreciated Assets	945,486			-	10	945,484	73
74	Allocated from Mgmt. Co.	268,772		16,639	16,639		102,590	74
75	TOTALS	\$ 1,711,569	\$ 48,021	\$ 57,562	\$ 9,541		\$ 1,455,361	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		Goshen 12 Passenger Bus	2017	\$ 9,900	\$	\$ 1,155	\$ 1,155	5	\$ 2,310	76
77		Allocated from Maestro Consulti	1900	576			-	5	576	77
78							-			78
79							-			79
80	TOTALS			\$ 10,476	\$	\$ 1,155	\$ 1,155		\$ 2,886	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)	\$ 9,752,808	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,822	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 373,323	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 242,501	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,036,702	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 55,785	92
93			93
94			94
95		\$ 55,785	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				4,294			5
6								6
7	TOTAL				\$ 4,294			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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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? _____

16. Rental Amount for movable equipment: \$ 107,321 Description: See Attached Schedule YES NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20	Allocated from Maestro Consulting			9,457	20
21	TOTAL		\$	\$ 9,457	21

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

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

Facility Name: California Gardens Nursing & Rehab Center
IDPH License ID Number: 0040022
Fiscal Year End: 12/31/18

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Bariatric Beds, Pressurized Mattresses, Wheelchair	76,667
Oxygen tanks, concentrators	691
Messenger Service	93
Copier	29,447
Postage Machine	537
Music over the paging system	1,159
Allocated from Maestro	10,633
Integra Allocation	(11,906)
Total - Line 16	<u>107,321</u>

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>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	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.)

	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(3)	hrs	\$	2,737	\$ 197,096	\$	2,737	\$ 197,096	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,412	101,648		1,412	101,648	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,060	220,290		3,060	220,290	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				97,271		97,271	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(7)					25,825		25,825	12
13	Other (specify): <u>See Sch 16A</u>	39(3)			479	34,467		479	34,467	13
14	TOTAL			\$	7,688	\$ 553,501	\$ 123,096	7,688	\$ 676,597	14

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

Facility Name: California Gardens Nursing & Rehab Center
IDPH License ID Number: 0040022
Fiscal Year End: 12/31/18

Schedule 16A

XIV. Special Services (Direct Cost)

Line 13 Other (specify)

Description	Units	Amount
I.V. Therapy Costs-Medicaid	140.97	10,150
I.V. Therapy Costs-Medicare A	4.31	310
I.V. Therapy Costs-Managed Care	270.69	19,490
I.V. Therapy Costs-Private	5.21	375
I.V. Therapy Costs-Veteran	55.93	4,027
Other Ancillary Costs-Veteran	1.60	115
Total - Line 13	479	34,467

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning: 01/01/18

Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 105,636	\$ 108,437	1
2	Cash-Patient Deposits	54,454	54,454	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,834,611</u>)	10,324,861	10,324,861	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	145,807	251,836	6
7	Other Prepaid Expenses	310,124	1,476,908	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See SCH 17A</u>	(252,354)	1,935,940	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,688,528	\$ 14,152,436	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		310,395	13
14	Buildings, at Historical Cost		4,802,317	14
15	Leasehold Improvements, at Historical Cost	1,390,126	2,918,051	15
16	Equipment, at Historical Cost	1,509,836	1,722,045	16
17	Accumulated Depreciation (book methods)	(2,281,059)	(7,036,702)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		199,903	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(33,796)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <u>CIP</u>	2,585	55,785	22
23	Other(specify): <u>See SCH 17A</u>	2,959,088	3,009,006	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,580,576	\$ 5,947,004	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,269,104	\$ 20,099,440	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,943,998	\$ 1,943,998	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,454	54,454	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	531,125	531,125	30
31	Accrued Taxes Payable (excluding real estate taxes)	77,995	77,995	31
32	Accrued Real Estate Taxes(Sch.IX-B)		578,791	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See SCH 17A</u>	12,339,319	13,554,266	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 14,946,891	\$ 16,740,629	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	230,745	13,552,886	39
40	Mortgage Payable			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)	\$ 230,745	\$ 13,552,886	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,177,636	\$ 30,293,515	46
47	TOTAL EQUITY(page 18, line 24)	\$ (908,532)	\$ (10,194,075)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,269,104	\$ 20,099,440	48

*(See instructions.)

Facility Name: California Gardens Nursing & Rehab Center
 IDPH License ID Number: 0040022
 Fiscal Year End: 12/31/18

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	After	
	Operating	Consolidation
NRC Accounts Receivable - Rent	(227,354)	1,612,868
NRC Miscellaneous Receivables	-	65,000
NRC Miscellaneous Receivables - Ins Recovery	-	104,611
NRC Due To/From - Chevy Chase Assoc.	(25,000)	(70,000)
NRC Due To/From - Nuvison	-	123,461
NRC Due To/From - Renaissance Healthcare	-	100,000
Total - Line 9	(252,354)	1,935,940

XV. Balance Sheet

Line 23 Long-Term Assets Other (specify):

Description	After	
	Operating	Consolidation
NRC Clearing Account	(13,741)	(13,741)
NRC Overhead Related/Party Due To/From Accts	-	67,026
NRC Due To/From - 87Th Street	(18)	(18)
NRC Due To/From - Bronzeville Park LLC	5,151	5,151
NRC Due To/From - Crestwood LLC	56,604	56,604
NRC Due To/From - Maple Ridge LLC	1	1
NRC Due To/From - Glendale	1,254,019	1,254,019
NRC Due To/From - Symphony ML	550,000	550,000
NRC Due To/From - Symphony Healthcare	467,350	467,350
NRC Due To/From - Symdiana Healthcare	404,500	404,500
NRC Due To/From - California Realty	548,745	548,745
NRC Due To/From - Maestro	(315,964)	(333,072)
NRC Due To/From - Aria - OLD	2,441	2,441
Total - Line 23	2,959,088	3,009,006

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
NRC CSA I/C Related/Party Due To/From Accts	7,539,162	7,539,162
NRC Due To/From - Evanston Healthcare LLC	214,860	214,860
NRC Due To/From - Jackson Square LLC	47,630	47,630
NRC Due To/From - Midway	(5,330)	(5,330)
NRC Due To/From - Morgan Park	(5,689)	(5,689)
NRC Due To/From - Tillers	55,500	55,500
NRC Due To/From - California Gardens Nursing and Reha	-	548,745
NRC Due To/From - Monroe Corp	228,000	228,000
NRC Due To/From - Crown Point LLC	321,738	321,738
NRC Due To/From - Dyer LLC	150,000	150,000
NRC Due To/From - Sycamore Healthcare	339,500	339,500
NRC Due To/From - Buffalo Grove - OLD	-	225,000
NRC Due To/From - Nucare Services	25,000	25,000
NRC Due To/From - Halsted Assoc.	-	131,000
NRC Due To/From - Jackson Assoc.	25,000	30,000
NRC Accrued Payables	38,680	38,680
NRC Accrued Payables - Professional Fees	30,714	30,714
NRC Accrued Payables - Health Insurance	78,547	78,547
NRC Accrued Payable - Dental Insurance	(1,293)	(1,293)
NRC Accrued Payables - Vision Insurance	(68)	(68)
NRC Accrued Payables - Life Insurance	1,148	1,148
NRC Accrued Payables - Short Term Disability	(1,103)	(1,103)
NRC Accrued Payables - Payroll Union Dues	(1,551)	(1,551)
NRC Accrued Payables - Payroll Credit Union	(77)	(77)
NRC Accrued Payables - 401K Deductions	680	680
NRC Accrued Payables - 401K Loan Repayments	1,440	1,440
NRC Accrued Payables - Heart and Soul Foundation	40	40
NRC Accrued Payables - Garmishments	7,002	7,002
NRC Accrued Payables - WC/GL Insurance	256,938	256,938
NRC Accrued Payables - Bed Taxes	423,760	423,760
NRC Accrued Payables - Bed Taxes Add'l	54,895	54,895
NRC Accrued Payables - Management Fees	962,521	962,521
NRC Accrued Payables - Interest	(333)	31,307
NRC Accrued Payables - Rent	1,542,128	1,542,128
NRC Deferred Rent	9,880	9,880
NRC Due NuCare	-	159,000
NRC Due Related Parties - Entity	-	114,562
Total - Line 36	12,339,319	13,554,266

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,332,996)	1
2	Restatements (describe):		2
3	Withdrawals	(349,999)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,682,995)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	774,463	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)	\$ 774,463	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)	\$ (908,532)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,396,899	1
2	Discounts and Allowances for all Levels	(1,049,520)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,347,379	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,184,517	6
7	Oxygen	638	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,185,155	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	129,698	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,383	19
20	Radiology and X-Ray	4,394	20
21	Other Medical Services	27,941	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 176,416	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income****	49,938	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,938	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See SCH 19A	215,797	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 215,797	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,974,685	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,293,748	31
32	Health Care	5,955,925	32
33	General Administration	3,925,804	33
B. Capital Expense			
34	Ownership	1,870,105	34
C. Ancillary Expense			
35	Special Cost Centers	1,374,925	35
36	Provider Participation Fee	779,715	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,200,222	40
41	Income before Income Taxes (line 30 minus line 40)**	774,463	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 774,463	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,973,175	44
45	Private Pay - Net Inpatient Revenue	105,258	45
46	Medicare - Net Inpatient Revenue	283,737	46
47	Other-(specify) Hospice / Veteran	906,531	47
48	Other-(specify) Managed Care / MAIP	6,078,678	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,347,379	49

* This must agree with page 4, line 45, column 4.
 ** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.
 ^ Entity is a cash basis taxpayer

Facility Name: California Gardens Nursing & Rehab Center
IDPH License ID Number: 0040022
Fiscal Year End: 12/31/18

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
NRC Preferred Insurance Provider Incentive - Revenue-	285,965
NRC Other Services - Revenue-Managed Care	(100,444)
NRC Transportation - Other Revenue-Other	12,704
NRC Other Income-Other	902
NRC Closing Costs & Adjustment to Prior Year Exp-Admin	16,670
Total - Line 28	<u>215,797</u>

Facility Name & ID Number California Gardens Nursing & Rehab Center

0040022

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	1,955	2,119	\$ 126,110	\$ 59.52	1
2	Assistant Director of Nursing	1,962	2,093	85,315	40.75	2
3	Registered Nurses	13,202	15,676	536,972	34.25	3
4	Licensed Practical Nurses	70,065	79,468	2,143,136	26.97	4
5	CNAs & Orderlies	120,066	137,046	1,800,684	13.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,216	15,860	200,371	12.63	10
11	Social Service Workers	7,451	7,941	224,586	28.28	11
12	Dietician					12
13	Food Service Supervisor	1,710	2,020	63,630	31.50	13
14	Head Cook	5,901	6,716	98,436	14.66	14
15	Cook Helpers/Assistants	18,020	19,790	239,996	12.13	15
16	Dishwashers					16
17	Maintenance Workers	11,735	13,217	212,182	16.05	17
18	Housekeepers	1,318	1,437	24,076	16.75	18
19	Laundry					19
20	Administrator	2,405	2,622	158,793	60.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,429	6,338	140,799	22.21	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	4,344	4,769	93,159	19.53	31
32	Other Health C: See Sch 20A	11,567	13,775	400,875	29.10	32
33	Other(specify) <u>Adm&CommRelat</u>	3,013	3,424	71,708	20.94	33
34	TOTAL (lines 1 - 33)	294,356	334,311	\$ 6,620,828 *	\$ 19.80	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	Monthly	\$ 21,464	1(3) 35
36	Medical Director	Monthly	36,000	9(3) 36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly	13,276	10(7) 38
39	Pharmacist Consultant	Monthly	30,159	10(3) 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	Monthly	7,837	39(7) 42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly	2,159	11(3) 44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>Dental Consultant</u>	Monthly	(300)	39(3) 47
48	<u>Psychiatric Consult</u>	Monthly	10,791	10(3) 48
49	TOTAL (lines 35 - 48)		\$ 121,386	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		N/A	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name: California Gardens Nursing & Rehab Center
IDPH License ID Number: 0040022
Fiscal Year End: 12/31/18

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS	5,457	6,593	213,788	\$ 32.43
Wound Care	6,110	7,182	187,087	\$ 26.05
Total - Line	11,567	13,775	400,875	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Martin Lee</u>	<u>Administrator</u>	<u>0</u>	\$ <u>158,793</u>	<u>Workers' Compensation Insurance</u>	\$ <u>63,119</u>	<u>IDPH License Fee</u>	\$ _____	
_____	_____	_____	_____	<u>Unemployment Compensation Insurance</u>	<u>44,257</u>	<u>Advertising: Employee Recruitment</u>	<u>239</u>	
_____	_____	_____	_____	<u>FICA Taxes</u>	<u>477,204</u>	<u>Health Care Worker Background Check</u>	_____	
_____	_____	_____	_____	<u>Employee Health Insurance</u>	<u>286,869</u>	<u>(Indicate # of checks performed <u>269</u>)</u>	<u>3,229</u>	
_____	_____	_____	_____	<u>Employee Meals</u>	_____	<u>Patient Background Checks</u>	<u>8,545</u>	
_____	_____	_____	_____	<u>Illinois Municipal Retirement Fund (IMRF)*</u>	_____	<u>Dues & Subscriptions</u>	<u>42,833</u>	
_____	_____	_____	_____	<u>Employee Retirement</u>	<u>52,113</u>	<u>Licenses & Fees</u>	<u>2,518</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 158,793	<u>Employee Benefits - Other</u>	<u>10,990</u>	<u>Health Care Council of Illinois</u>	<u>7,572</u>	
(List each licensed administrator separately.)			\$ 158,793	<u>Employees' Physical Exams</u>	<u>7,551</u>	_____	_____	
B. Administrative - Other			_____	<u>401K</u>	<u>4,821</u>	<u>Allocated from Maestro Consulting</u>	<u>7,603</u>	
Description			Amount			<u>Less: Public Relations Expense</u>	<u>(19,305)</u>	
<u>Management Fees - Maestro Consulting</u>			\$ <u>830,189</u>			<u>Non-allowable advertising</u>	(_____)	
_____			_____			<u>Yellow page advertising</u>	(_____)	
_____			_____			TOTAL (agree to Sch. V,	\$ <u>53,234</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 830,189	TOTAL (agree to Schedule V, line 22, col.8)		line 20, col. 8)		
(Attach a copy of any management service agreement)			\$ 830,189					
C. Professional Services			_____	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount		
<u>Ability Network, Inc</u>	<u>Secure Exc. Mngd. Services</u>	\$ <u>8,946</u>		_____	_____	\$ _____		
<u>Allscripts</u>	<u>IT System</u>	<u>3,517</u>		_____	_____	_____		
<u>Alteryx, Inc</u>	<u>Data Analytics</u>	<u>450</u>		_____	_____	_____		
<u>American Express</u>	<u>Internet</u>	<u>5,728</u>		_____	_____	_____		
<u>CDW Government</u>	<u>Computer Software</u>	<u>385</u>		_____	_____	_____		
<u>Cerida Investment Corp.</u>	<u>Business Services</u>	<u>632</u>		_____	_____	_____		
<u>Cisco Systems Capital Corp.</u>	<u>Software</u>	<u>329</u>		_____	_____	_____		
<u>Comcast Cable</u>	<u>Internet</u>	<u>24,673</u>		_____	_____	_____		
<u>Corporation Service Company</u>	<u>Annual Filing</u>	<u>260</u>		_____	_____	_____		
<u>Creative Technology Solutions</u>	<u>IT Support</u>	<u>26,307</u>		_____	_____	_____		
<u>Dart Chart</u>	<u>Software</u>	<u>8,868</u>		_____	_____	_____		
<u>See Supplemental Schedule</u>	_____	<u>529,029</u>		_____	_____	_____		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 609,124	TOTAL		\$ _____		
(For legal fee disclosure, see page 39 of instructions)			\$ 609,124					

* Attach copy of IMRF notifications

**See instructions.

Facility Name: California Gardens Nursing & Rehab Center
 IDPH License ID Number: 0040022
 Fiscal Year End: 12/31/18

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Data Robot, Inc.	Computer Services	1,829
Digital Marketing Seo & Web Design	Branding	589
Formation Healthcare Group, LLC	Montly Subscription Fee	1,486
Fyi Systems, Inc.	Computer IT	614
Health Data Systems Inc	Programming	4,105
Life Safety Resources, LLC	Construction Management	3,145
LTC Consulting Services	Billing	109,305
Maestro Consulting, LLC	Consulting Services	144,059
Managed Care Group LLC	IT Support	1,466
Marcum	Accreditation	997
Matrixcare	Monthly Accounts Receivable Look-up Service	10,807
McCabe Kirshner P.C.	Legal	114,543
Mood Media	Branding	47
Mts Consulting, LLC	Tax Consulting	7,180
National Datacare Corporation	Trust fund and Medicaid billing services	5,071
Neal, Gerber & Eisenberg, LLP	Legal	87
Nexuscomm, LLC	Cable	4,675
Personnel Planners, Inc	Qtrly Unemployment Claims	2,094
Pointclickcare Technologies Inc.	Cloud Based Software and Services	53,337
Prime Care Technologies	PBJ Reporting Module Access Fee	273
Real Time Medical Systems LLC	Clinical and Financial Analytis Service	4,950
RSM US LLP	Accounting	26,773
SB2 Inc.	Legal	3,123
Scott Norton	Computer Consulting	431
Snowflake Computing, Inc.	Computer Services	980
Stone Pogrud & Korey LLC	Legal	75
Telemedicine Solutions, LLC	Wound Rounds Care	22,926
Tracking System	Computer Services	66
Wencel Worldwide, Inc.	Branding	3,996
	From Page 21	80,095
	Total (agree to Schedule V, line 19, column 3)	609,124
Allocated from Management Company	Professional Services	130,524
Allocated from Management Company	Professional Services	17,064
Less: Non-Allowable Legal Fees		(75)
Less: Non-Allowable Pro Fees		
	Total (agree to Schedule V, line 19, column 8)	756,637

Facility Name & ID Number California Gardens Nursing & Rehab Center# 0040022Report Period Beginning: 01/01/18Ending: 12/31/18**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. Health Care Council of Illinois \$7,572
- (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? 20
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10(3)
- (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. \$ 779,715
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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? Yes
Firm Name: RSM US LLP
- (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.