



Facility Name & ID Number Maple Crest Care Centre

# 0051839 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	86	Skilled (SNF)	86	31,390	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	86	TOTALS	86	31,390	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	3 Private Pay	4 Other	4 Total	
8	SNF			6,029	6,029	8
9	SNF/PED					9
10	ICF	14,421	7,326	488	22,235	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,421	7,326	6,517	28,264	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.04%

D. How many bed-hold days during this year were paid by the Department?

N/A (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  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 01/01/2012

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

YES  Date 12/31/2011 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 86 and days of care provided 5,174

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name &amp; ID Number

Maple Crest Care Centre

# 0051839

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	194,726	17,578	6,811	219,115		219,115		219,115		1
2	Food Purchase		151,446		151,446		151,446		151,446		2
3	Housekeeping	62,950	27,018		89,968		89,968		89,968		3
4	Laundry	57,591	18,109	3,318	79,018		79,018		79,018		4
5	Heat and Other Utilities			86,375	86,375		86,375	316	86,691		5
6	Maintenance	68,761	3,562	88,675	160,998		160,998	1,875	162,873		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>384,028</b>	<b>217,713</b>	<b>185,179</b>	<b>786,920</b>		<b>786,920</b>	<b>2,191</b>	<b>789,111</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			27,660	27,660		27,660		27,660		9
10	Nursing and Medical Records	1,570,715	91,390	6,537	1,668,642		1,668,642	(861)	1,667,781		10
10a	Therapy	27,387			27,387		27,387		27,387		10a
11	Activities	56,016		9,809	65,825		65,825		65,825		11
12	Social Services	37,859		4,608	42,467		42,467		42,467		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,691,977</b>	<b>91,390</b>	<b>48,614</b>	<b>1,831,981</b>		<b>1,831,981</b>	<b>(861)</b>	<b>1,831,120</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	89,978		308,137	398,115		398,115	(308,137)	89,978		17
18	Directors Fees										18
19	Professional Services			148,491	148,491		148,491	8,864	157,355		19
20	Dues, Fees, Subscriptions & Promotions			20,886	20,886		20,886	(2,454)	18,432		20
21	Clerical & General Office Expenses	230,363	19,439	26,795	276,597		276,597	65,330	341,927		21
22	Employee Benefits & Payroll Taxes			486,470	486,470		486,470		486,470		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,325	3,325		3,325	554	3,879		24
25	Other Admin. Staff Transportation			9,432	9,432		9,432		9,432		25
26	Insurance-Prop.Liab.Malpractice			171,558	171,558		171,558	4,074	175,632		26
27	Other (specify):* <b>Mgmt alloc of benef</b>							12,525	12,525		27
28	<b>TOTAL General Administration</b>	<b>320,341</b>	<b>19,439</b>	<b>1,175,094</b>	<b>1,514,874</b>		<b>1,514,874</b>	<b>(219,244)</b>	<b>1,295,630</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,396,346</b>	<b>328,542</b>	<b>1,408,887</b>	<b>4,133,775</b>		<b>4,133,775</b>	<b>(217,914)</b>	<b>3,915,861</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Maple Crest Care Centre

#0051839

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			12,375	12,375		12,375	1,046	13,421			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,552	15,552		15,552	(15,552)				32
33	Real Estate Taxes			54,892	54,892		54,892		54,892			33
34	Rent-Facility & Grounds			841,357	841,357		841,357	5,046	846,403			34
35	Rent-Equipment & Vehicles			51,179	51,179		51,179	38	51,217			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			975,355	975,355		975,355	(9,422)	965,933			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			7,633	7,633		7,633		7,633			38
39	Ancillary Service Centers		138,784	747,506	886,290		886,290		886,290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,241	187,241		187,241		187,241			42
43	Other (specify):* <b>Non-Allowable Co</b>	(1,025)		200,560	199,535		199,535	(199,535)				43
44	<b>TOTAL Special Cost Centers</b>	(1,025)	138,784	1,142,940	1,280,699		1,280,699	(199,535)	1,081,164			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,395,321	467,326	3,527,182	6,389,829		6,389,829	(426,871)	5,962,958			45

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

Facility Name & ID Number Maple Crest Care Centre

# 0051839

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(3,685)	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				9
10	Interest and Other Investment Income	(15,552)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,296)	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	(1,704)	43		18
19	Entertainment				19
20	Contributions	(9,637)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,141)	43		24
25	Fund Raising, Advertising and Promotional	(8,753)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(150)	43		28
29	Other-Attach Schedule See Pg 5A	(71,063)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (217,981)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(208,890)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (208,890)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (426,871)</b>		<b>37</b>

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

## Maple Crest Care Centre

ID# 0051839

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (28,894)	43	1
2	Laboratory Costs	(18,435)	43	2
3	X-Ray Costs	(15,929)	43	3
4	Theft Damage and Loss	(255)	43	4
5	Nonallowable Legal Expense	(50)	43	5
6	Marketing Bonus	1,025	43	6
7	Lobbying expense	(2,844)	20	7
8	Other Medicare & Medicare HMO	(5,681)	43	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(71,063)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V			N/A				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	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	\$	Symphony Financial Services, LLC	100.00%	\$ 316	\$	316	15
16	V	6 Maintenance		Symphony Financial Services, LLC	100.00%	1,875		1,875	16
17	V	10 Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	(861)		(861)	17
18	V	17 Administrative	308,137	Symphony Financial Services, LLC	100.00%			(308,137)	18
19	V	19 Professional Services-Other		Symphony Financial Services, LLC	100.00%	8,914		8,914	19
20	V	20 Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	390		390	20
21	V	21 Clerical & General Office Exp-Salaries		Symphony Financial Services, LLC	100.00%	65,330		65,330	21
22	V	24 Travel & Seminar		Symphony Financial Services, LLC	100.00%	554		554	22
23	V	26 Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	4,074		4,074	23
24	V	27 Other		Symphony Financial Services, LLC	100.00%	12,525		12,525	24
25	V	30 Depreciation		Symphony Financial Services, LLC	100.00%	1,046		1,046	25
26	V	34 Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	5,046		5,046	26
27	V	35 Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	38		38	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$ 308,137			\$ 99,247	\$ *	(208,890)	39

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

Facility Name &amp; ID Number

Maple Crest Care Centre

# 0051839

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony Decatur		Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid Aurora		Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of Crestwood		Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of Joliet		Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Crest Belvidere					5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony Lincoln					6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co Decatur					7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood Belvidere					8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7527 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Seasons Hospice	Park Ridge	Work Comp Ins.	13
14			Claremont - Hanover Park	Hanover Park	JLR Financial Service	Lincolnwood	Hospice	14
15			Claridge Imperial, LTD.	Chicago	KFT Services, LLC	Lincolnwood	Management Co.	15
16			Jackson Corp	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	Clinical Consulting Se	Lincolnwood	Management Co.	17
18			Renaissance at 87th Street	Chicago	Quest Services Corp	Lincolnwood	Clinical Consult	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	Marketing	19
20			Renaissance at South Shore	Chicago	Maple Leaf Insurance	Grand Cayman	DME & Medical Su	20
21			Renaissance at Park South	Chicago				21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona				24
25			Renaissance West	Mesa, Arizona				25
26			Renaissance Village IL	Mesa, Arizona				26
27			Renaissance Village AL	Mesa, Arizona				27
28								28
29								29
30								30

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## 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 Maple Crest Care Centre

# 0051839

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Symphony Financial Services, LLC  
 Street Address 7358 N. Lincoln, Suite 120  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number (847) 933-2600  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Occupied Bed Days	422,236	8	\$ 4,728	28,264	\$ 316	1
2	6	Maintenance	Occupied Bed Days	422,236	8	28,009	28,264	1,875	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	422,236	8	(12,869)	(12,869)	(861)	3
4	19	Professional Services-Legal	Occupied Bed Days	422,236	8	6,403	28,264	429	4
5	19	Professional Services-Other	Occupied Bed Days	422,236	8	126,762	28,264	8,485	5
6	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	422,236	8	5,823	28,264	390	6
7	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	422,236	8	929,524	929,524	62,221	7
8	21	Clerical & Gen ofc exp	Occupied Bed Days	422,236	8	46,441	28,264	3,109	8
9	24	Travel & Seminar	Occupied Bed Days	422,236	8	8,276	28,264	554	9
10	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	422,236	8	60,868	28,264	4,074	10
11	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	422,236	8	187,104	28,264	12,525	11
12	30	Depreciation	Occupied Bed Days	422,236	8	15,633	28,264	1,046	12
13	34	Rent-Facility & Grounds	Occupied Bed Days	422,236	8	75,378	28,264	5,046	13
14	35	Rent-Equipment & Vehicles	Occupied Bed Days	422,236	8	572	28,264	38	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,482,652	\$ 916,655	\$ 99,247	25

Facility Name & ID Number

Maple Crest Care Centre

# 0051839

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	<b>Working Capital</b>																
6	The Private Bank		X	Line of Credit	Interest Only	12/30/2013	17,520,000	502,144	06/10/2014	0.0550	15,552						
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$ 17,520,000	\$ 502,144			\$ 15,552						
	<b>B. Non-Facility Related*</b>																
10																	
11																	
12									Interest Income Offset		(15,552)						
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (15,552)						
15	<b>TOTALS (line 9+line14)</b>						\$ 17,520,000	\$ 502,144			\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* 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

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>			
1. Real Estate Tax accrual used on 2012 report.		\$ 47,200	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.)	2012	\$ 49,772	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 2,572	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 52,320	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 54,892	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2008	45,731	8
	2009	51,151	9
	2010	54,125	10
	2011	44,123	11
	2012	49,772	12
<b>2013 Tax Accrual = \$49,772 * 1.05 = 52,206.60; Use \$52,320</b>			
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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



Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                YES       X   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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Maple Crest Care Centre

# 0051839 Report Period Beginning:

01/01/2013 Ending:

12/31/2013

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 36,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

N/A

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

Facility Name & ID Number Maple Crest Care Centre

# 0051839

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		F&I Smoke Detector above fire alarm control panel	2013		3,725	130	27.5	130		130	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											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Maple Crest Care Centre

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,725	\$ 130		\$ 130	\$	\$ 130	70

\*\*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	\$ 23,750	\$ 4,749	\$ 4,749	\$	5	\$ 6,103	71
72	Current Year Purchases	86,544	7,496	7,496		5-7	7,496	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.	9,805		1,046	1,046	5-7	1,085	74
75	TOTALS	\$ 120,099	\$ 12,245	\$ 13,291	\$ 1,046		\$ 14,684	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 123,824	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,375	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,421	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,046	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,814	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	N/A	\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Diana Master Landlord, LLC

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:	<u>1972</u>	<u>86</u>	<u>12/31/2011</u>	\$ <u>839,819</u>	<u>10</u>	<u>10</u>	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				<u>5,046</u>			6
7	TOTAL		<u>86</u>		\$ <u>844,865</u>			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. 12/31/2014                      \$ 600,000

13. 12/31/2015                      \$ 612,000

14. 12/31/2016                      \$ 624,000

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 10.

1,538

15,379

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 51,217 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

Symphony Maple Crest  
FYE: December 31, 2013  
Provider Number - 0051839

Schedule 14A

B (16) Movable Equipment Rental

<u>Rental Description</u>	<u>Amount</u>
Mattress	7,051
VAC Freedom	23,815
Suction Machine	167
E Tank Regulator	146
Mist Therapy Equipment	1,039
Electric Bed	120
Blood Pressure Machine	990
Dish Machine	1,984
Helium	43
Cooler	320
Copier	4,214
Kyocera Printer	9,160
Computer	1,079
Sound System	194
Office Equipment	856
Allocated from Mgmt. Co.	<u>38</u>
	<u><u>51,217</u></u>

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,499	\$	323,917	\$	4,499	\$	323,917	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		956		69,307		956		69,307	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39(3)	hrs		4,796		345,319		4,796		345,319	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39(2)	# of prescrpts					138,784			138,784	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>See Schedule 16A</u>	39(3)			124		8,963		124		8,963	12
13	Other (specify):											13
14	<b>TOTAL</b>			\$	10,375	\$	747,506	\$	138,784	\$	886,290	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.

Symphony Maple Crest  
FYE: December 31, 2013  
Provider Number - 0051839

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost)

12. Other

Description	Units	Amount
INHALATION THERAPY-PRIVATE	46	3,324
INHALATION THERAPY-MEDICAI	72	5,188
PHYSICIANS-MEDICARE	1	70
PHYSICIANS-VETERAN	1	54
RESPIRATORY	5	327
	<u>124</u>	<u>8,963</u>

Facility Name & ID Number Maple Crest Care Centre# 0051839Report Period Beginning: 01/01/2013

Ending:

12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 104,647	\$ 104,647	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>105,141</u> )	1,646,171	1,646,171	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	250	250	6
7	Other Prepaid Expenses	65,363	65,363	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	238,222	238,222	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,054,653	\$ 2,054,653	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,725	3,725	15
16	Equipment, at Historical Cost	110,294	120,099	16
17	Accumulated Depreciation (book methods)	(13,729)	(14,814)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Lease cost, net</u>	12,303	12,303	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 112,593	\$ 121,313	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,167,246	\$ 2,175,966	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 271,005	\$ 271,005	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,825	88,825	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,320	52,320	32
33	Accrued Interest Payable	30	30	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	621,922	621,922	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,034,102	\$ 1,034,102	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	502,144	502,144	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 502,144	\$ 502,144	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,536,246	\$ 1,536,246	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 631,000	\$ 639,720	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,167,246	\$ 2,175,966	48

\*(See instructions.)

Symphony Maple Crest  
 FYE: December 31, 2013  
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Schedule 17A

XV. Balance Sheet  
 Line 9 Other (specify):

Description	After	
	Operating	Consolidation
Cash in Bank - Trust Account	8,913	8,913
Medicaid Coinsurance Receivable	30,988	30,988
Security Deposit	102,004	102,004
Real Estate Escrow Deposit	73,402	73,402
Construction in Progress	22,915	22,915
Total - Line 9	238,222	238,222

XV. Balance Sheet  
 Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Security Deposit Payable	42,768	42,768
Operating Expenses	151,081	151,081
Management Fees - Symphony	91,719	91,719
Ins. Workmans Comp Deduct/Settlement	40,401	40,401
State Unemployment Tax	5,564	5,564
Sales Tax	913	913
Payroll Taxes Other	9,246	9,246
Deferred Rent	44,999	44,999
Accrued Employee Benefits	151,604	151,604
FICA & W/H Fed	366	366
Due to IDPA - Add'tl Bed Tax	48,530	48,530
Due to/From the Kinsington	17,810	17,810
Due to Nucare	9,608	9,608
Wage Assignments-Garnishment	456	456
Patient Personal Funds	6,857	6,857
	621,922	621,922

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 147,111	1
2	Restatements (describe):		2
3	<b>Prior Period Adjustment</b>	(2)	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 147,109	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	483,891	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 483,891	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 631,000	24 *

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

Facility Name & ID Number Maple Crest Care Centre# 0051839Report Period Beginning: 01/01/2013Ending: 12/31/2013

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,636,258	1
2	Discounts and Allowances for all Levels	(1,441,008)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,195,250</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,459,819	6
7	Oxygen	333	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,460,152</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	147,913	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,457	19
20	Radiology and X-Ray	3,517	20
21	Other Medical Services	22,726	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 195,613</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	22,664	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 22,664</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Medicare and Managed Care Rentals</b>	41	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 41</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,873,720</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	786,920	31
32	Health Care	1,831,981	32
33	General Administration	1,514,874	33
<b>B. Capital Expense</b>			
34	Ownership	975,355	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,093,458	35
36	Provider Participation Fee	187,241	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,389,829</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>483,891</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 483,891</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,177,769	44
45	Private Pay - Net Inpatient Revenue	1,157,109	45
46	Medicare - Net Inpatient Revenue	1,517,071	46
47	Other-(specify) <u>Hospice</u>	74,381	47
48	Other-(specify) <u>Managed Care</u>	268,920	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,195,250</b>	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.

^ Tax return prepared on cash basis.

Facility Name & ID Number Maple Crest Care Centre

# 0051839

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**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	1,626	1,850	\$ 67,465	\$ 36.47	1
2	Assistant Director of Nursing	2,721	2,868	93,043	32.44	2
3	Registered Nurses	7,047	7,690	252,697	32.86	3
4	Licensed Practical Nurses	17,184	18,789	475,364	25.30	4
5	CNAs & Orderlies	53,399	57,038	682,146	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,107	2,290	27,387	11.96	8
9	Activity Director	4,945	5,441	56,016	10.30	9
10	Activity Assistants					10
11	Social Service Workers	1,868	2,051	37,859	18.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,432	15,554	194,726	12.52	15
16	Dishwashers					16
17	Maintenance Workers	4,034	4,319	68,761	15.92	17
18	Housekeepers	6,889	7,272	62,950	8.66	18
19	Laundry	6,149	6,668	57,591	8.64	19
20	Administrator	1,873	2,051	89,978	43.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,906	2,051	46,904	22.86	23
24	Clerical	7,401	7,995	183,459	22.95	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing Bonus</u>			(1,025)		33
34	TOTAL (lines 1 - 33)	133,582	143,927	\$ 2,395,321 *	\$ 16.64	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	\$ 6,811	1(3)	35
36	Medical Director	Monthly	27,660	9(3)	36
37	Medical Records Consultant	Monthly	876	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,661	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,782	11(3)	44
45	Social Service Consultant	Monthly	4,608	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,398		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



XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Hipp Law Office	Legal Fees	50
Much Shelist	Legal Fees	384
Stone, McGuire & Siegel	Legal Fees	14,617
Ability Network Inc	Secure Exchange Managed Services	1,747
AON E Solutions Inc	Risk Management Software/Maint	1,458
Comcast	Internet	22,462
Dell Markeing	Microsoft Licensing	594
Ehealth Data Solutions	Carewatch Billing	4,780
EITech	Logitech Webcam	82
Emdeon Business Servies	Billing	215
Evault Inc	Protect One Services	2,718
HDSI	Data Processing	2,846
HK Payroll Services	Work Tax Credit	205
IIT/SourceTech	Operator Monthly Support Fee	1,380
Joe Park	Review Resumes	38
Mark Hartman	Web Hosting	12
McGladrey	Accounting	13,662
Personnel Planners Inc	Qtrly Unemployment Claims	996
Pinnacle Quality	Customer Satisfaction	2,550
Point B Communication	Yrly Web Hosting	144
Provinent Solutions	Outsourced IT Services	6,471
PSD Solutions	Network Integration Service	1,833
Symphony Financial	Profession Fees	50,053
Telemedicine Solutions	Wound Rounds Care	6,386
Verizon	Internet	50
Wescom Solutions	Data Processing	12,589
Zirmed	Eligibility Verification	170
<b>Total agreeing to Schedule V, Line 19, Col 3</b>		<b>148,491</b>

Allocated from Management Company Legal Fees 429

Allocated from Management Company Professional Services 8,485

Nonallowable Legal

(50)

**Total (agree to Schedule V, line 19, column 8)** 157,355

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3										N/A		
4												
5												
6												
7												
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12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Maple Crest Care Centre# 0051839Report Period Beginning: 01/01/2013 Ending: 12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council LTC - \$8,617
- (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 - ICLTC \$8,617
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? Yes
- (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? 5-7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 527 Line 10(2)
- (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. \$ 187,241  
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? No 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. \$ 5
- 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: McGladrey LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.