



Facility Name & ID Number Maple Crest Care Centre

# 0051839 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,053	7,813	6,560	29,426	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,053	7,813	6,560	29,426	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.74%

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 5,044

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name &amp; ID Number

Maple Crest Care Centre

# 0051839

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

**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	190,170	17,256	7,516	214,942		214,942		214,942		1
2	Food Purchase		154,785		154,785		154,785		154,785		2
3	Housekeeping	72,424	25,281		97,705		97,705		97,705		3
4	Laundry	45,718	5,337	6,166	57,221		57,221		57,221		4
5	Heat and Other Utilities			94,595	94,595		94,595	263	94,858		5
6	Maintenance	70,749	586	117,044	188,379		188,379	2,801	191,180		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	379,061	203,245	225,321	807,627		807,627	3,064	810,691		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,400	24,400		24,400		24,400		9
10	Nursing and Medical Records	1,690,221	98,260	892	1,789,373		1,789,373	30,865	1,820,238		10
10a	Therapy	28,522			28,522		28,522		28,522		10a
11	Activities	69,038		8,975	78,013		78,013		78,013		11
12	Social Services	39,305		3,304	42,609		42,609		42,609		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Mgmt alloc of benef</b>							4,019	4,019		15
16	<b>TOTAL Health Care and Programs</b>	1,827,086	98,260	37,571	1,962,917		1,962,917	34,884	1,997,801		16
	<b>C. General Administration</b>										
17	Administrative	113,030		327,273	440,303		440,303	(327,232)	113,071		17
18	Directors Fees										18
19	Professional Services			145,547	145,547		145,547	22,259	167,806		19
20	Dues, Fees, Subscriptions & Promotions			34,294	34,294		34,294	(10,881)	23,413		20
21	Clerical & General Office Expenses	152,848	19,934	29,133	201,915		201,915	124,191	326,106		21
22	Employee Benefits & Payroll Taxes			466,143	466,143		466,143		466,143		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,294	5,294		5,294	4,773	10,067		24
25	Other Admin. Staff Transportation			5,255	5,255		5,255	(1,605)	3,650		25
26	Insurance-Prop.Liab.Malpractice			217,412	217,412		217,412	6,041	223,453		26
27	Other (specify):* <b>Mgmt alloc of benef</b>							22,719	22,719		27
28	<b>TOTAL General Administration</b>	265,878	19,934	1,230,351	1,516,163		1,516,163	(159,735)	1,356,428		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,472,025	321,439	1,493,243	4,286,707		4,286,707	(121,787)	4,164,920		29

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

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

Facility Name &amp; ID Number

Maple Crest Care Centre

#0051839

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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			48,952	48,952		48,952	2,356	51,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,297	1,297		1,297	(96)	1,201			32
33	Real Estate Taxes			54,644	54,644		54,644	260	54,904			33
34	Rent-Facility & Grounds			817,054	817,054		817,054	(31,252)	785,802			34
35	Rent-Equipment & Vehicles			38,649	38,649		38,649	2,916	41,565			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			960,596	960,596		960,596	(25,816)	934,780			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			5,927	5,927		5,927		5,927			38
39	Ancillary Service Centers		155,360	779,150	934,510		934,510		934,510			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,078	195,078		195,078		195,078			42
43	Other (specify):* <b>Non-Allowable Co</b>			198,561	198,561		198,561	(198,561)				43
44	<b>TOTAL Special Cost Centers</b>		155,360	1,178,716	1,334,076		1,334,076	(198,561)	1,135,515			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,472,025	476,799	3,632,555	6,581,379		6,581,379	(346,164)	6,235,215			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: 01/01/2015

Ending: 12/31/2015

**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	(5,926)	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	(155)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,710)	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	8	43		18
19	Entertainment				19
20	Contributions	(11,477)	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	(108,921)	43		24
25	Fund Raising, Advertising and Promotional	(5,885)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(132)	43		28
29	Other-Attach Schedule See Page 5A	(81,066)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (215,264)</b>		<b>\$</b>	<b>30</b>

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)	(130,900)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (130,900)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (346,164)</b>		<b>37</b>

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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					45
46	Other-Attach Schedule					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: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (44,900)	43	1
2	Laboratory Costs	(9,322)	43	2
3	X-Ray Costs	(9,871)	43	3
4	Nonallowable Legal Expense	(2,198)	43	4
5	Lobbying expense	(12,503)	20	5
6	Marketing Travel	(1,847)	25	6
7	Valet Parking	(425)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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>		(81,066)	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							2
3	V	N/A						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	Total		\$			\$	\$ * 0	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%	\$ 205	\$	205	15
16	V	6 Maintenance		Symphony Financial Services, LLC	100.00%	1,477		1,477	16
17	V	10 Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	20,696		20,696	17
18	V	15 Other		Symphony Financial Services, LLC	100.00%	3,800		3,800	18
19	V	17 Administrative	271,528	Symphony Financial Services, LLC	100.00%			(271,528)	19
20	V	19 Professional Services		Symphony Financial Services, LLC	100.00%	22,318		22,318	20
21	V	20 Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	477		477	21
22	V	21 Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	98,761		98,761	22
23	V	24 Travel & Seminar		Symphony Financial Services, LLC	100.00%	4,127		4,127	23
24	V	26 Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	6,041		6,041	24
25	V	27 Other		Symphony Financial Services, LLC	100.00%	17,523		17,523	25
26	V	30 Depreciation		Symphony Financial Services, LLC	100.00%	1,906		1,906	26
27	V	34 Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(33,578)		(33,578)	27
28	V	35 Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	2,083		2,083	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>		\$ 271,528			\$ 145,836	\$ *	(125,692)	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	<u>5</u> Utilities	\$	Maestro Consulting Services	100.00%	\$ 58	\$	58	15
16	V	<u>6</u> Maintenance Salaries		Maestro Consulting Services	100.00%	954		954	16
17	V	<u>6</u> Maintenance Expenses		Maestro Consulting Services	100.00%	370		370	17
18	V	<u>7</u> Employee Benefits - Maintenance		Maestro Consulting Services	100.00%	219		219	18
19	V	<u>10</u> Clinical Salaries		Maestro Consulting Services	100.00%	10,169		10,169	19
20	V	<u>15</u> Employee Benefits - Clinical		Maestro Consulting Services	100.00%	2,326		2,326	20
21	V	<u>17</u> Administrative Salaries	55,745	Maestro Consulting Services	100.00%	41		(55,704)	21
22	V	<u>19</u> Professional Fees		Maestro Consulting Services	100.00%	2,139		2,139	22
23	V	<u>20</u> Dues, Fees, Subscriptions, Etc.		Maestro Consulting Services	100.00%	1,145		1,145	23
24	V	<u>21</u> Clerical & General Salaries		Maestro Consulting Services	100.00%	22,676		22,676	24
25	V	<u>21</u> Clerical & General Expenses		Maestro Consulting Services	100.00%	2,754		2,754	25
26	V	<u>24</u> Seminars & Education		Maestro Consulting Services	100.00%	646		646	26
27	V	<u>25</u> Transportation		Maestro Consulting Services	100.00%	242		242	27
28	V	<u>27</u> Employee Benefits - Administrative		Maestro Consulting Services	100.00%	5,196		5,196	28
29	V	<u>30</u> Depreciation		Maestro Consulting Services	100.00%	450		450	29
30	V	<u>32</u> Interest Expense		Maestro Consulting Services	100.00%	59		59	30
31	V	<u>33</u> Real Estate Tax		Maestro Consulting Services	100.00%	260		260	31
32	V	<u>35</u> Equipment Rental		Maestro Consulting Services	100.00%	596		596	32
33	V	<u>35</u> Auto Lease		Maestro Consulting Services	100.00%	237		237	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$ 55,745			\$ 50,537	\$ *	(5,208)	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:

01/01/2015

Ending:

12/31/2015

## 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	Symphony of Evanston Healthcare	Evanston				9
10	David J. Hartman	20.00	Symphony of Dyer	Indiana				10
11	Jay Flatt	3.00	Symphony of Crown Point	Indiana	Nucare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Gerry Jenich	10.00			7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Bronzeville Park	Chicago	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Claremont Rehab. & Living	Buffalo Grove	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Claremont - Hanover Park	Hanover Park	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Claridge Imperial, LTD.	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Jackson Corp	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Monroe Pavillion	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at 87th Street	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Renaissance at Midway	Chicago				22
23			Renaissance at South Shore	Chicago				23
24			Renaissance at Park South	Chicago	* No expense paid by h			24
25			Aria Post Acute Care	Hillside	entity, therefore no pa			25
26			Seven Oaks	Glendale, Wiscosin	** No expense of this r			26
27			Renaissance East	Mesa, Arizona	allocated to homes			27
28			Renaissance West	Mesa, Arizona				28
29			Renaissance Village IL	Mesa, Arizona				29
30			Renaissance Village AL	Mesa, Arizona				30

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

## 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	<b>No owners receive compensation from this facility.</b>								\$		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:

01/01/2015

Ending: 2/31/2015

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 7257 N. Lincoln Ave,  
 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	372,277	11	\$ 3,116	\$ 24,539	\$ 205	1
2	6	Maintenance	Occupied Bed Days	372,277	11	22,405	24,539	1,477	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	372,277	11	313,972	313,972	20,696	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,277	11	57,644	24,539	3,800	4
5	19	Professional Services-Legal	Occupied Bed Days	372,277	11	5,442	24,539	359	5
6	19	Professional Services-Other	Occupied Bed Days	372,277	11	333,134	24,539	21,959	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	372,277	11	7,234	24,539	477	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	372,277	11	1,244,063	1,244,063	82,004	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	372,277	11	254,217	24,539	16,757	9
10	24	Travel & Seminar	Occupied Bed Days	372,277	11	62,607	24,539	4,127	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	372,277	11	91,654	24,539	6,041	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	372,277	11	265,831	24,539	17,523	12
13	30	Depreciation	Occupied Bed Days	372,277	11	28,917	24,539	1,906	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	372,277	11	(509,407)	24,539	(33,578)	14
15	35	Rent - Equipment	Occupied Bed Days	372,277	11	14,362	24,539	947	15
16	35	Rent - Vehicles	Occupied Bed Days	372,277	11	17,234	24,539	1,136	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,212,425	\$ 1,558,035	\$ 145,836	25

Facility Name & ID Number Maple Crest Care Centre

# 0051839 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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 Maestro Consulting Services  
 Street Address 7257 N. Lincoln Ave,  
 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	Bed Days Available	307,257	28	\$ 3,424	\$ 5,246	\$ 58	1
2	6	Maintenance Salaries	Bed Days Available	307,257	28	55,893	5,246	954	2
3	6	Maintenance Expenses	Bed Days Available	307,257	28	21,648	5,246	370	3
4	7	Employee Benefits - Maintenance	Bed Days Available	307,257	28	12,799	5,246	219	4
5	10	Clinical Salaries	Bed Days Available	307,257	28	595,582	5,246	10,169	5
6	15	Employee Benefits - Clinical	Bed Days Available	307,257	28	136,244	5,246	2,326	6
7	17	Administrative Salaries	Bed Days Available	307,257	28	2,420	5,246	41	7
8	19	Professional Fees	Bed Days Available	307,257	28	125,288	5,246	2,139	8
9	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	307,257	28	67,058	5,246	1,145	9
10	21	Clerical & General Salaries	Bed Days Available	307,257	28	1,328,131	5,246	22,676	10
11	21	Clerical & General Expenses	Bed Days Available	307,257	28	161,289	5,246	2,754	11
12	24	Seminars & Education	Bed Days Available	307,257	28	37,815	5,246	646	12
13	25	Transportation	Bed Days Available	307,257	28	14,185	5,246	242	13
14	27	Employee Benefits - Administrative	Bed Days Available	307,257	28	304,341	5,246	5,196	14
15	30	Depreciation	Bed Days Available	307,257	28	26,334	5,246	450	15
16	32	Interest Expense	Bed Days Available	307,257	28	3,464	5,246	59	16
17	33	Real Estate Tax	Bed Days Available	307,257	28	15,239	5,246	260	17
18	35	Equipment Rental	Bed Days Available	307,257	28	34,911	5,246	596	18
19	35	Auto Lease	Bed Days Available	307,257	28	13,885	5,246	237	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,959,950	\$ 1,982,026	\$ 50,537	25



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2014 report.			\$	<u>53,500</u>	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.)	2014		\$	<u>52,744</u>	2										
3. Under or (over) accrual (line 2 minus line 1).			\$	(756)	3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>55,400</u>	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										
		Allocated from Mgmt Co.		260											
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.			\$	<u>54,904</u>	7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>54,125</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2011	<u>44,123</u>	9												
	2012	<u>49,772</u>	10												
	2013	<u>50,908</u>	11												
	2014	<u>52,744</u>	12												
<b>2015 Tax Accrual = \$52,744 * 1.05 = 55,381.20; Use \$53,400</b>															

**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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Maple Crest Care Centre

# 0051839 Report Period Beginning:

01/01/2015 Ending:

12/31/2015

**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>Alloc Fr Maestro 7257</u>		<u>2004</u>	<u>\$ 455</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 455</b>	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				\$	\$		\$	\$	\$
5									
6									
7									
8	Allocated from Maestro 7257	2004		4,098		39	105	105	1,420
<b>Improvement Type**</b>									
9	F&I Smoke Detector above fire alarm control panel in		2013	3,725	187	20	187		504
10	100 Wing Nurse Station								
11									
12	Facility Remodeling		2014	395,662	19,847	20	19,847		34,898
13	-Demo/carpentry/drywall throughout facility								
14	-Railing throughout facility								
15	-Pulled wires for lights, rough in & installed can lights in								
16	200 Wing Spa								
17	-Rough in fire place area, rough in floor box in								
18	200 Wing Spa								
19	-Hallway, restrooms, dining room & recreation room -								
20	remove wallpaper & prep wall								
21	-Spa wall and floor tile in salon								
22	-Plumbing work done in salon								
23	-Electrical throughout facility								
24	-Interior painting in resident rooms, front offices,								
25	reception area and therapy room								
26	-Floor coverings throughout facility								
27	-Vestibule work								
28	-Automatic doors throughout Facility								
29	-Permits								
30	-Gazebo outside								
31	-Architectural services								
32	-General contractors fees								
33									
34									
35									
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 &amp; 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	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	Architecture fee, Electric power for new entrance door	2015	\$ 10,187	\$ 424	20	\$ 424	\$	\$ 424	37
38	Repair broken drain pipe, Kitchen floor	2015	4,995	167	20	167		167	38
39	Dark bronze glass and aluminum door and frame	2015	19,144	80	20	80		80	39
40	-1 dining room, 1 end of 100 Hallway (LTC) and 200 Hallway								40
41									41
42	Allocated from Maestro Consulting Services	2003	200		39	2	2	120	42
43	Allocated from Maestro Consulting Services	2004	4,060		39	39	39	2,382	43
44	Allocated from Maestro Consulting Services	2005	241		39	2	2	129	44
45	Allocated from Maestro Consulting Services	2006	326		39	3	3	150	45
46	Allocated from Maestro Consulting Services	2008	344		39	3	3	122	46
47	Allocated from Maestro Consulting Services	2009	5,539		20	54	54	1,784	47
48	Allocated from Maestro Consulting Services	2010	851		20	8	8	192	48
49	Allocated from Maestro Consulting Services	2011	46		20			11	49
50	Allocated from Maestro Consulting Services	2012	51		20			9	50
51	Allocated from Maestro Consulting Services	2014	640		20	6	6	46	51
52	Allocated from Maestro Consulting Services	2015	180		20			2	52
53									53
54									54
55									55
56	Allocated from Maestro 7257	2004	81		10			47	56
57	Allocated from Maestro 7257	2005	374		10	3	3	247	57
58	Allocated from Maestro 7257	2015	65		15	3	3	1	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)		\$ 450,810	\$ 20,705		\$ 20,936	\$ 231	\$ 42,734	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	\$ 148,030	\$ 27,715	\$ 27,715	\$	5-7	\$ 65,729	71
72	Current Year Purchases	4,121	532	532		5-7	532	72
73	Fully Depreciated Assets							73
74	See Sch 13A	41,154		2,124	2,124	5-7	21,963	74
75	TOTALS	\$ 193,305	\$ 28,247	\$ 30,371	\$ 2,124		\$ 88,224	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Maestro Consulting Services			\$ 151	\$	\$ 1	\$ 1		\$ 151	76
77										77
78										78
79										79
80	TOTALS			\$ 151	\$	\$ 1	\$ 1		\$ 151	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)	\$ 644,721	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,952	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,308	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,356	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 131,109	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.

**Facility Name:** Maple Crest Care Centre  
**IDPH License ID Number:** 0051839  
**Fiscal Year End:** 12/31/2015

**Schedule 13A**

**XI. Ownership Costs**

**Line 74 - Equipment Costs - Excluding Transportation**

<b>Category of Equipment</b>	<b>Cost</b>	<b>Current Book Depreciation</b>	<b>Straight Line Depreciation</b>	<b>Adjustments</b>	<b>Component Life</b>	<b>Accumulated Depreciation</b>
Allocated from Symphony Financial Services, LLC	11,661		1,906	1,906	5-7	4,679
Allocated from Maestro Consulting Services	29,493		218	218	5-10	17,284
				-		
<b>TOTAL</b>	41,154	-	2,124	2,124		21,963

Facility Name & ID Number Maple Crest Care Centre

# 0051839

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

**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>815,516</u>	<u>10</u>	<u>10</u>	3
4	Additions							4
5								5
6	<u>Allocated from Mgmt. Co.</u>				<u>(31,252)</u>			6
7	TOTAL		<u>86</u>		\$ <u>784,264</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.	<u>/2016</u>	\$ <u>624,000</u>
-----	--------------	-------------------

13.	<u>/2017</u>	\$ <u>636,725</u>
-----	--------------	-------------------

14.	<u>/2018</u>	\$ <u>649,460</u>
-----	--------------	-------------------

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: \$ 38,649

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			\$	\$	17
18					18
19					19
20	<u>Allocated from Mgmt. Co.</u>			<u>2,916</u>	20
21	TOTAL		\$	\$ <u>2,916</u>	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: Maple Crest Care Centre  
IDPH License ID Number: 0051839  
Fiscal Year End: 12/31/2015

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Mattress	4,209
VAC Freedom	6,519
E Tank Regulator	1,823
Blood Pressure Machine	2,376
Dish Machine	2,071
Room Temp cooler	150
Copier	8,556
Printer	5,346
Computer	1,079
Sound System	392
Office Equipment	5,975
E Cylinder	89
Liquid Reservoir	8
HR Machine	56
<b>Total - Line 16</b>	<b><u>38,649</u></b>

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		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	\$	4,513	\$	324,938	\$	4,513	\$	324,938	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,209		87,039		1,209		87,039	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39(3)	hrs		4,738		341,140		4,738		341,140	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					150,225			150,225	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)					26,033				26,033	12	
13	Other (specify): <u>Oxygen</u>	39(2)						5,135			5,135	13	
14	TOTAL			\$	10,460	\$	779,150	\$	155,360	10,460	\$	934,510	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: Maple Crest Care Centre  
IDPH License ID Number: 0051839  
Fiscal Year End: 12/31/2015

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<u>Description</u>	<u>Units</u>	<u>Amount</u>
INHALATION THERAPY-PRIVATE		174
INHALATION THERAPY-MEDICARE		14,115
INHALATION THERAPY-MEDICAID		3,957
INHALATION THERAPY-MANAGED CARE		2,585
I.V. THERAPY-MEDICARE		2,831
PHYSICIANS-MEDICARE		217
INHALATION THERAPY-MEDICARE		35
INHALATION THERAPY-MEDICAID		91
OTHER OUTSIDE SERV-PENDING		398
PROGRAM CONSULTANT		965
OTHER SERVICES - MEDICARE		665
<b>Total - Line 12</b>	<b>-</b>	<b>26,033</b>

Facility Name & ID Number Maple Crest Care Centre# 0051839Report Period Beginning: 01/01/2015

Ending:

12/31/2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 159,111	\$ 159,111	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>201,017</u> )	1,416,999	1,416,999	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	250	250	6
7	Other Prepaid Expenses	89,770	89,770	7
8	Accounts Receivable (owners or related parties)	1,486,788	1,486,788	8
9	Other(specify): <u>Reserve</u>	29,185	29,185	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,182,103	\$ 3,182,103	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		455	13
14	Buildings, at Historical Cost		4,098	14
15	Leasehold Improvements, at Historical Cost	457,716	446,712	15
16	Equipment, at Historical Cost	152,152	193,456	16
17	Accumulated Depreciation (book methods)	(102,390)	(131,109)	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>	9,227	9,227	22
23	Other(specify): <u>Deposits</u>	246,168	246,168	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 762,873	\$ 769,007	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,944,976	\$ 3,951,110	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 861,492	\$ 861,492	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,926	106,926	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,400	55,400	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	1,086,801	1,086,801	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,110,619	\$ 2,110,619	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	84,646	84,646	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>	\$ 84,646	\$ 84,646	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,195,265	\$ 2,195,265	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,749,711	\$ 1,755,845	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,944,976	\$ 3,951,110	48

\*(See instructions.)

**Facility Name:** Maple Crest Care Centre  
**IDPH License ID Number:** 0051839  
**Fiscal Year End:** 12/31/2015

**Schedule 17A**

**XV. Balance Sheet**

**Line 36 Other Current Liabilities (specify):**

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Exchange Formation L/H	432,710	432,710
Security Deposit Payable	11,142	11,142
Operating Expenses	188,519	188,519
Management Fees - Symphony	67,547	67,547
Ins. Wrks Deduct/Settlement	117,738	117,738
Accumulated Amortization Def	(28,791)	(28,791)
State Unemployment Tax	4,354	4,354
Federal Unemployment Tax	600	600
Sales Tax	342	342
Payroll Taxes Other	11,062	11,062
Accrued Employee Benefits	96,871	96,871
FICA & W/H Fed	16	16
Due to IDPA - Add'tl Bed Tax	24,833	24,833
Due to Kensington Group	17,684	17,684
Exchange	100,651	100,651
Due to NuCare	9,608	9,608
Due to Symphony Financial	25,952	25,952
Wage Assignments	107	107
Patient Personal Funds	5,856	5,856
<b>Total - Line 36</b>	<b><u>1,086,801</u></b>	<b><u>1,086,801</u></b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,061,680	1
2	Restatements (describe):		2
3	Prior Period Adjustment	1,204	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,062,884	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	686,827	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)	\$ 686,827	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,749,711	24 *

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

Facility Name & ID Number Maple Crest Care Centre# 0051839Report Period Beginning: 01/01/2015Ending: 12/31/2015

**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	\$ 7,039,341	1
2	Discounts and Allowances for all Levels	(1,565,055)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,474,286</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,559,989	6
7	Oxygen	2,480	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,562,469</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	173,173	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,795	19
20	Radiology and X-Ray	8,116	20
21	Other Medical Services	13,107	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 231,191</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	155	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 155</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>	<b>105</b>	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 105</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,268,206</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	807,627	31
32	Health Care	1,962,917	32
33	General Administration	1,516,163	33
<b>B. Capital Expense</b>			
34	Ownership	960,596	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,138,998	35
36	Provider Participation Fee	195,078	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>\$ 6,581,379</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>686,827</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 686,827</b>	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,424,956	44
45	Private Pay - Net Inpatient Revenue	1,208,330	45
46	Medicare - Net Inpatient Revenue	1,441,271	46
47	Other-(specify) <u>Hospice</u>	240,902	47
48	Other-(specify) <u>Managed Care</u>	158,827	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,474,286</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: 01/01/2015

Ending: 12/31/2015

**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	1,773	1,826	\$ 83,613	\$ 45.79	1
2	Assistant Director of Nursing	3,535	3,744	121,855	32.55	2
3	Registered Nurses	10,845	11,643	323,761	27.81	3
4	Licensed Practical Nurses	17,363	18,373	459,038	24.98	4
5	CNAs & Orderlies	51,684	55,790	669,557	12.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,677	1,976	28,522	14.43	8
9	Activity Director	5,591	6,040	69,038	11.43	9
10	Activity Assistants					10
11	Social Service Workers	1,896	2,107	39,305	18.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,562	15,718	190,170	12.10	15
16	Dishwashers					16
17	Maintenance Workers	3,791	4,154	70,749	17.03	17
18	Housekeepers	7,778	8,317	72,424	8.71	18
19	Laundry	4,932	5,176	45,718	8.83	19
20	Administrator	1,849	2,046	113,030	55.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,787	4,059	93,288	22.98	23
24	Clerical	2,370	2,632	59,560	22.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,490	1,704	32,397	19.01	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,923	145,305	\$ 2,472,025 *	\$ 17.01	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	\$ 7,516	1(3)	35
36	Medical Director	Monthly	24,400	9(3)	36
37	Medical Records Consultant	Monthly	892	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				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	2,958	11(3)	44
45	Social Service Consultant	Monthly	3,304	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 39,070		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53



**Facility Name:** Maple Crest Care Centre  
**IDPH License ID Number:** 0051839  
**Fiscal Year End:** 12/31/2015

**Schedule 21A**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
Ability Network	Secure Exchange Managed Services	1,516
BOA - M/Hartman	Web Hosting	8
Comcast Business	Internet	11,020
Constant Care Technology	Care Connection	3,137
Creative Technology	IT Support	6,464
Ehealth Data Solutions	Carewatch Billing	4,780
Evault Inc	Protect One Services	2,736
HDSI	Data Processing	3,297
Hipp Law Office	Legal Fees	2,198
HK Payroll Services	Work Tax Credit	180
IIT/SourceTech	Operator Monthly Support Fee	1,380
Medical Business Office	Collection Agency	789
Microsoft Corporation	Micro Software	276
Much Shelist	Legal Fees	457
Personnel Planners Inc	Qtrly Unemployment Claims	1,603
PointB Communication	Yrly Web Hosting	680
RSM US LLP	Accounting	17,264
Stone Pogrund & Korey	Legal Fees	120
Stone, McGuire & Siegel	Legal Fees	15,485
Symphony Post Acute	Administrative Consultant	50,000
Telemedicine Solutions LLC	Wound Rounds Care	8,419
Wescom Solutions	Data Processing	13,258
Zirmed	Eligibility Verification	482
	<b>Total (agree to Schedule V, line 19, column 3)</b>	<b>145,547</b>

Allocated from Management Company Legal Fees 359

Allocated from Management Company Professional Services	24,098
Less: Non-Allowable Legal Fees	(2,198)
<b>Total (agree to Schedule V, line 19, column 8)</b>	<u><u>167,806</u></u>

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												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Maple Crest Care Centre# 0051839Report Period Beginning: 01/01/2015 Ending: 12/31/2015**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 - \$17,585
- (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? 5-7 Yr
- (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(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. \$ 195,078  
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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.