

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0040428

Facility Name: Maplewood Care

Address: 50 North Jane Drive Elgin 60123
Number City Zip Code

County: Kane

Telephone Number: (847) 697-3750 Fax # (847) 697-5385

HFS ID Number:

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	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	<u>44,464</u>	<u>1,029</u>	<u>4,081</u>	<u>49,574</u>	8
9	SNF/PED					9
10	ICF	<u>18,158</u>	<u>376</u>		<u>18,534</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>62,622</u>	<u>1,405</u>	<u>4,081</u>	<u>68,108</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.92%

D. How many bed-hold days during this year were paid by the Department? 2,077 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 04/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/1993 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 203 and days of care provided 2,868

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	281,628	31,547	42,408	355,583		355,583	(16,927)	338,656			1
2	Food Purchase		335,107		335,107	(33,803)	301,304	(69)	301,235			2
3	Housekeeping	263,843	51,448		315,291		315,291	(1,754)	313,537			3
4	Laundry	67,574	20,340		87,914		87,914	(665)	87,249			4
5	Heat and Other Utilities			183,737	183,737		183,737	(23,836)	159,901			5
6	Maintenance	45,119	41,920	241,971	329,010		329,010	(34,247)	294,763			6
7	Other (specify):*							7,568	7,568			7
8	TOTAL General Services	658,164	480,362	468,116	1,606,642	(33,803)	1,572,839	(69,930)	1,502,909			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,224,613	189,799	352,098	2,766,510		2,766,510	(34,307)	2,732,203			10
10a	Therapy	157,792	3,005	49,670	210,467		210,467	(14,861)	195,606			10a
11	Activities	117,339	19,465	2,448	139,252		139,252		139,252			11
12	Social Services	235,865		13,500	249,365		249,365		249,365			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,664	5,664			15
16	TOTAL Health Care and Programs	2,735,609	212,269	424,916	3,372,794		3,372,794	(43,505)	3,329,289			16
	C. General Administration											
17	Administrative	89,743		543,053	632,796		632,796	(436,940)	195,856			17
18	Directors Fees											18
19	Professional Services			232,405	232,405	(955)	231,450	(126,036)	105,414			19
20	Dues, Fees, Subscriptions & Promotions			61,316	61,316		61,316	(35,192)	26,124			20
21	Clerical & General Office Expenses	248,654	29,453	232,280	510,387		510,387	(47,965)	462,422			21
22	Employee Benefits & Payroll Taxes			503,425	503,425	33,803	537,228		537,228			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,835	7,835		7,835	601	8,436			24
25	Other Admin. Staff Transportation			10,578	10,578		10,578	9,739	20,317			25
26	Insurance-Prop.Liab.Malpractice			141,921	141,921		141,921	1,594	143,515			26
27	Other (specify):*							43,395	43,395			27
28	TOTAL General Administration	338,397	29,453	1,732,813	2,100,663	32,848	2,133,511	(590,804)	1,542,707			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,732,170	722,084	2,625,845	7,080,099	(955)	7,079,144	(704,239)	6,374,905			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			90,528	90,528		90,528	230,709	321,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,022	20,022		20,022	374,110	394,132			32
33	Real Estate Taxes					955	955	116,642	117,597			33
34	Rent-Facility & Grounds			925,000	925,000		925,000	(925,000)				34
35	Rent-Equipment & Vehicles			4,560	4,560		4,560	7,088	11,648			35
36	Other (specify):*							30,224	30,224			36
37	TOTAL Ownership			1,040,110	1,040,110	955	1,041,065	(166,227)	874,838			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,876	381,806	534,682		534,682		534,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			373,143	373,143		373,143		373,143			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		152,876	754,949	907,825		907,825		907,825			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,732,170	874,960	4,420,904	9,028,034		9,028,034	(870,465)	8,157,569			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(26,468)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	206,409	30		9
10	Interest and Other Investment Income	(5,639)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,150)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(133,645)	21		24
25	Fund Raising, Advertising and Promotional	(12,235)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,232)	20		28
29	Other-Attach Schedule	(55,178)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,707)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(822,759)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (822,759)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (870,465)		37

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

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

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

Maplewood Care

	ID#	0040428
Report Period Beginning:		01/01/11
Ending:		12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Bank Fees	\$ (5,322)	21	1
2	Theft and Damage Loss	(33)	21	2
3	Additional R&M	12,017	06	3
4	Prior Period Replacement Tax	(528)	21	4
5	Miscellaneous Income	(1,500)	21	5
6	Non-Allowable Legal	(4,884)	19	6
7	COPE Dues	(4,738)	20	7
8	Non-Allowable Seminar Add to 2012	(105)	24	8
9	Capitalized R&M	(31,980)	06	9
10	Filing Fee- Building Co.	(309)	20	10
11	Office Expense- Building Co.	(214)	21	11
12	Professional Fees- Building Co.	(6,007)	19	12
13	Prior Period Expense	(1,379)	10	13
14	Prior Period Expense	(2,177)	21	14
15	CMS Penalty	(7,020)	20	15
16	State Replacement Tax	(1,000)	21	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(55,178)		49

Maplewood Care

ID#

0040428

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 925,000	Maplewood- Jane, LLC	100.00%	\$	\$ (925,000)	1
2	V	32	Interest Income	783	Maplewood- Jane, LLC	100.00%		(783)	2
3	V	36	Amortization		Maplewood- Jane, LLC	100.00%	30,224	30,224	3
4	V	30	Depreciation		Maplewood- Jane, LLC	100.00%	15,895	15,895	4
5	V	20	Filing Fees		Maplewood- Jane, LLC	100.00%	309	309	5
6	V	32	Interest Expense		Maplewood- Jane, LLC	100.00%	382,185	382,185	6
7	V	21	Office Expense		Maplewood- Jane, LLC	100.00%	214	214	7
8	V	33	Real Estate Taxes		Maplewood- Jane, LLC	100.00%	110,031	110,031	8
9	V	19	Professional Fees		Maplewood- Jane, LLC	100.00%	6,007	6,007	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 925,783			\$ 544,865	\$ * (380,918)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	6	REPAIRS AND MAINT.	\$ 24,360	S.I.R. MANAGEMENT, INC.	100.00%	\$ 10,816	\$ (13,544)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	859	859	16
17	V	10	NURSING	48,720	S.I.R. MANAGEMENT, INC.	100.00%	15,835	(32,885)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,721	2,721	18
19	V	19	PROFESSIONAL FEES	150,492	S.I.R. MANAGEMENT, INC.	100.00%	12,959	(137,533)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,183	1,183	20
21	V	21	CLERICAL & GENERAL	48,720	S.I.R. MANAGEMENT, INC.	100.00%	53,280	4,560	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	706	706	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,739	9,739	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,470	1,470	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,672	4,672	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(8,900)	(8,900)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,088	7,088	27
28	V								28
29	V	17	ADMINISTRATIVE	543,053	S.I.R. MANAGEMENT, INC.	100.00%	27,106	(515,947)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,947		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	100,107	100,107	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,883	20,883	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 815,345			\$ 262,471	\$ * (554,821)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1	DIETARY SALARIES	\$ 24,360	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,433	\$ (16,927)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,292	1,292	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,732	7,732	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,338	1,338	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	79,007	79,007	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	15,369	15,369	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	17,840	17,840	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	24,360	S.I.R. MANAGEMENT, INC.	100.00%	9,499	(14,861)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,605	1,605	25
26	V								26
27	V	6	MAINTENANCE SALARIES	28,842	S.I.R. MANAGEMENT, INC.	100.00%	27,025	(1,817)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	5,417	5,417	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,632	2,632	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,077	1,077	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	57	57	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	73	73	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	124	124	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,405	8,405	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,247	7,247	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,611	6,611	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	955	955	38
39	Total			\$ 77,562			\$ 200,737	\$ * 123,175	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1	Dietary	\$	Xcel Supply, LLC	100.00%	\$	\$	15
16	V	3	Housekeeping	28,930	Xcel Supply, LLC	100.00%	27,176	(1,754)	16
17	V	4	Laundry	10,977	Xcel Supply, LLC	100.00%	10,312	(665)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	128,255	Xcel Supply, LLC	100.00%	120,480	(7,775)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 168,163			\$ 157,968	\$ * (10,195)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CSS Employee Benefit Group	100.00%	\$ 111,934	\$ 111,934	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	111,934	CSS Employee Benefit Group	100.00%		(111,934)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 111,934			\$ 111,934	\$ *	39

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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	ADAM VALES TRUST	2.985%	ALBANY CARE INC	EVANSTON	MAPLEWOOD-JANE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BRYAN BARRISH TRUST DTD 09/01/2004	12.998%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	CELESTE GIANNINI TRUST DTD 3/13/00	10.510%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	CHARLENE HILL -JEON	2.488%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	4
5	DANIEL ROTHNER TRUST	2.985%	ELMWOOD CARE, INC.	ELMWOOD PARK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	DENNIS TOSSI	0.995%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	GALE ROTHNER	7.463%	GREENWOOD CARE, INC.	EVANSTON				7
8	HARVEY SCOTT	0.995%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	JEFF ORAVEC	0.498%	REGENCY REHABILITATION CENTER,LLC	NILES				9
10	JOEY ABRAMCHIK	2.488%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11	JULIANA R. BARRISH TRUST DTD 1/26/93	12.998%	WILSON CARE, INC.	CHICAGO				11
12	KATHRYN VALES TRUST	2.985%	APPLEWOOD REHAB CENTER, LLC	MATTESON				12
13	KIMBERLY RICHMAN TRUST	2.985%						13
14	LORI BARRISH	0.995%						14
15	LOUISE BERGTHOLD	5.970%						15
16	MELISSA ROTHNER TRUST	2.985%						16
17	MICHAEL R GIANNINI TRUST DTD 3/13/00	17.973%						17
18	RACHEL ROTHNER TRUST	2.985%						18
19	THOMAS WINTER	2.736%						19
20	WILLIAM ROTHNER TRUST	2.985%						20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Bryan Barrish	Relative	Administrative	12.99%	See Attached	3.25	7.22%	Alloc. Salary	\$ 16,263	17-7	1
2	Michael Giannini	Relative	Administrative	17.97%	See Attached	2.85	7.13%	Alloc. Salary	13,580	17-7	2
3	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.07	8.14%	Alloc. Salary	7,433	1-7	3
4	Louise Bergthold	Shareholder	Administrative	5.97%	See Attached	0.98	1.63%	Alloc. Salary	3,417	17-7	4
5	Tom Winter	Shareholder	Administrative	2.74%	See Attached	4.88	8.13%	Alloc. Salary	16,263	17-7	5
6	Jeff Oravec	Shareholder	Administrative	0.50%	See Attached	3.25	8.13%	Alloc. Salary	10,843	17-7	6
7	Joey Abramchik	Shareholder	Administrative	2.49%	See Attached	3.66	8.13%	Alloc. Salary	15,369	17-7	7
8	Elka Abramchick	Relative	Clerical	0.00%	See Attached	2.6	8.13%	Alloc. Salary	3,225	21-7	8
9	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	3.25	8.13%	Alloc. Salary	3,661	21-7	9
10	Sarah Barrish	Relative	Administrative	0.00%	See Attached	4.07	8.14%	Alloc. Salary	9,737	17-7	10
11	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.54	1.35%	Alloc. Salary	2,109	17-7	11
12	See second page 7 for the detail of the additional owner and related compensation										12
13								TOTAL	\$ 101,900		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Ending: 12/31/11

(847) 675 -0555

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY SALARIES	PATIENT DAYS	837,569	13	\$ 91,408	\$ 91,408	68,108	\$ 7,433	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		68,108	1,292	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	68,108	7,732	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		68,108	1,338	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	68,108	79,007	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		68,108	15,369	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		68,108	17,840	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	24,360	9,499	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		24,360	1,605	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	28,842	27,025	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		28,842	5,417	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		1,047	2,632	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		1,047	1,077	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		1,047	57	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		1,047	73	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		1,047	124	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		1,047	8,405	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		1,047	7,247	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		1,047	6,611	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		1,047	955	24
25	TOTALS					\$ 2,490,426	\$ 1,625,498		\$ 200,737	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, IL 60202
Phone Number (847)328-7600
Fax Number (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$	\$			1
2	3	Housekeeping	Direct Allocation						27,176	2
3	4	Laundry	Direct Allocation						10,312	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						120,480	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation							10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		157,968	25

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 111,934	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 111,934	25

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Alloc.-Maplewood Care		X	Note Payable			\$	8,062,440			\$	382,185	1
2	Shareholder Loan	X						800,000					2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				1,475,000				20,022	6
7	Alloc. - SIR Managment	X										7,247	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	10,337,440			\$	409,454	9
	B. Non-Facility Related*												
10	Interest Income		X									(5,639)	10
11	Bldg. Partnership Int. Income		X									(783)	11
12	Alloc. - SIR Management	X										(8,900)	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(15,322)	14
15	TOTALS (line 9+line14)						\$	10,337,440			\$	394,132	15

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	107,500	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.)		\$	112,642	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	5,142	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	111,500	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		\$	955	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. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	117,597	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	96,112	8	
		2007	95,557	9	
		2008	96,692	10	
		2009	102,344	11	
		2010	106,031	12	
2011 Accrual = \$106,031 x 1.05 =~ \$111,500					
Allocated from S.I.R. Management = \$7,556					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Maplewood Care</u>	COUNTY	<u>Kane</u>
FACILITY IDPH LICENSE NUMBER	<u>0040428</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-1111</u>	FAX #:	<u>(847) 236-1155</u>

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Maplewood Care	COUNTY	Kane
---------------	----------------	--------	------

FACILITY IDPH LICENSE NUMBER 0040428

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,780

B. General Construction Type: Exterior Brick Frame _____ 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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>517,253</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 517,253	3

SEE ACCOUNTANTS' COMPILATION REPORT

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				1972	\$ 5,445,306	\$ 15,895	35	\$ 155,580	\$ 139,685	\$ 2,874,624	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	98,204		20	2,160	2,160	64,482	9
10	Various			1994	13,684		20	684	684	12,576	10
11	Various			1995	5,179		20	259	259	4,264	11
12	Various			1996	19,800		20	990	990	15,675	12
13	Various			1997	21,688		20	1,084	1,084	16,104	13
14	Various			1998	19,077		20	954	954	12,674	14
15	Various			1999	35,671		20	2,193	2,193	27,156	15
16	Various			2000	565,082		20	28,254	28,254	333,923	16
17	Various			2001	72,848		20	3,401	3,401	47,431	17
18	Various			2002	15,524		20	1,281	1,281	12,509	18
19	Various			2003	22,349		20	1,117	1,117	9,620	19
20	Various			2004	18,088		20	1,099	1,099	8,079	20
21	Various			2005	114,777		20	5,739	5,739	37,064	21
22	Various			2006	278,330		20	13,917	13,917	76,857	22
23	Various			2007	37,791		20	1,890	1,890	8,818	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

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	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	133,779	3,825		5,445	1,620	63,931	68
69	Financial Statement Depreciation		90,528			(90,528)		69
70	TOTAL (lines 4 thru 69)	\$ 6,917,177	\$ 110,248		\$ 226,048	\$ 115,800	\$ 3,625,786	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,917,177	\$ 110,248		\$ 226,048	\$ 115,800	\$ 3,625,786	1
2	Elevator Work	2008	8,500		20	425	425	1,665	2
3	Plumbing Work	2008	13,948		20	358	358	1,356	3
4	Paving	2008	58,878		20	3,925	3,925	14,392	4
5	Water Heater	2008	7,918		20	792	792	2,903	5
6	Elevator Work	2008	3,060		20	153	153	523	6
7	Window Treatments	2008	12,623		20	2,525	2,525	8,415	7
8	Bathrooms- Plumbing, Walls, Tiles, Electrical, New Fixtures	2008	26,200		20	2,620	2,620	8,733	8
9	Isolation Valves / Internal Shower Valves	2008	2,713		20	136	136	520	9
10	Hvac Work	2008	14,200		20	1,420	1,420	4,497	10
11	Bathrooms- Plumbing, Walls, Tiles, Electrical, New Fixtures	2009	27,600		20	1,380	1,380	4,140	11
12	Pavers	2009	14,800		20	740	740	1,603	12
13	Hvac Compressor & Contactor	2009	2,873		20	144	144	371	13
14	Hvac Compressor	2009	2,831		20	142	142	366	14
15	Master Key System	2009	2,915		20	146	146	364	15
16	Hvac Compressor	2009	3,430		20	172	172	414	16
17	Heat Exchanger	2009	2,978		20	149	149	335	17
18	Rooftop Hvac Units	2009	20,370		20	2,037	2,037	3,395	18
19	Camera	2010	6,230		20	1,246	1,246	1,973	19
20	Window Treatments	2010	9,999		20	2,000	2,000	3,000	20
21	Nurse Stations	2010	44,761		20	8,952	8,952	14,174	21
22	Replace Door	2010	2,745		20	137	137	229	22
23	Compressor Repair	2010	3,129		20	156	156	235	23
24	Compressor Repair	2010	2,860		20	143	143	226	24
25	Hallway Room Signs	2011	6,855		20	400	400	400	25
26	Elevator Hydraulic Pump	2011	9,082		20	265	265	265	26
27	Elevator Interior Work	2011	10,070		20	336	336	336	27
28	Flooring & Wall-Base	2011	5,752		20	144	144	144	28
29	Ceiling Grid	2011	34,930		20	1,019	1,019	1,019	29
30	Wallcoverings	2011	3,616		20	422	422	422	30
31	Window Treatments	2011	14,156		20	354	354	354	31
32	Water Heater	2011	4,306		20	90	90	90	32
33	Handrails, Crashrails, Corner Guards	2011	76,093		20	951	951	951	33
34	TOTAL (lines 1 thru 33)		\$ 7,377,598	\$ 110,248		\$ 259,924	\$ 149,676	\$ 3,703,596	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,377,598	\$ 110,248		\$ 259,924	\$ 149,676	\$ 3,703,596	1
2	Hvac Rooftop Unit	2011	20,964		20	349	349	349	2
3	Painting	2011	51,280		20	427	427	427	3
4	Wallpaper	2011	83,106		20	1,385	1,385	1,385	4
5	Elevator Hydraulic Pump	2011	9,082		20	1,060	1,060	1,060	5
6	Flooring, Wallbase, Wallcoverings	2011	56,318		20	1,643	1,643	1,643	6
7	Wallcoverings	2011	4,314		20	108	108	108	7
8	Painting	2011	5,675		20	213	213	213	8
9	Landscaping Plants And Bark	2011	2,866		20	143	143	143	9
10	Landscaping, Green Boxwood, Black Eyed Susan, Campanula Wh	2011	7,954		20	398	398	398	10
11	Heat Exchanger #9	2011	2,817		20	141	141	141	11
12	Heat Exchanger #8 Replacement	2011	2,991		20	150	150	150	12
13	Partial Blower Replacement 400 Wing	2011	2,559		20	128	128	128	13
14	New Corner Guards	2011	4,301		20	215	215	215	14
15	Heating And Cooling Unit Repair	2011	2,659		20	133	133	133	15
16	Domestic Hot Water System	2011	3,328		20	166	166	166	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,637,812	\$ 110,248		\$ 266,582	\$ 156,334	\$ 3,710,254	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,637,812	\$ 110,248		\$ 266,582	\$ 156,334	\$ 3,710,254	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,637,812	\$ 110,248		\$ 266,582	\$ 156,334	\$ 3,710,254	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,637,812	\$ 110,248		\$ 266,582	\$ 156,334	\$ 3,710,254	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,637,812	\$ 110,248		\$ 266,582	\$ 156,334	\$ 3,710,254	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	S.I.R. Properties- S.I.R. Management- Allocation	1993	36,797	1,168	35	1,051	(117)	18,398	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	S.I.R. Properties- S.I.R. Management- Allocation	2010	2,220		20	111	111	148	9
10	S.I.R. Properties- S.I.R. Management- Allocation	2009	2,209	193	20	110	(83)	309	10
11	S.I.R. Properties- S.I.R. Management- Allocation	2007	644	53	20	32	(21)	161	11
12	S.I.R. Properties- S.I.R. Management- Allocation	2002	146		20	7	7	70	12
13	S.I.R. Properties- S.I.R. Management- Allocation	1999	4,663		20	233	233	2,914	13
14	S.I.R. Properties- S.I.R. Management- Allocation	1998	2,228		20	111	111	1,504	14
15	S.I.R. Properties- S.I.R. Management- Allocation	1997	139		20	7	7	108	15
16	S.I.R. Properties- S.I.R. Management- Allocation	1994	350	9	20	18	9	306	16
17	S.I.R. Properties- S.I.R. Management- Allocation	1993	597	3	20	30	27	552	17
18									18
19	S.I.R. Management- Allocation	1993	9,329	260	20	463	203	8,787	19
20	S.I.R. Management- Allocation	1994	29		20			29	20
21	S.I.R. Management- Allocation	1995	213		20	11	11	175	21
22	S.I.R. Management- Allocation	1997	14,335	321	20	703	382	10,601	22
23	S.I.R. Management- Allocation	1999	1,127		20	56	56	690	23
24	S.I.R. Management- Allocation	1999	11,357		20			11,357	24
25	S.I.R. Management- Allocation	2000	1,331		20	66	66	768	25
26	S.I.R. Management- Allocation	2007	4,276	394	20	214	(180)	897	26
27	S.I.R. Management- Allocation	2008	11,784	1,126	20	743	(383)	2,856	27
28	S.I.R. Management- Allocation	2009	29,281	268	20	1,464	1,196	3,286	28
29	S.I.R. Management- Allocation	2011	724	30	20	15	(15)	15	29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$133,779	\$3,825		\$5,445	\$1,620	\$63,931	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$361,125	\$4,218	\$49,061	\$44,843	10	\$561,845	71
72	Current Year Purchases	180,061	9	5,172	5,163	10	5,172	72
73	Fully Depreciated Assets	646,074		18	18	10	646,074	73
74								74
75	TOTALS	\$1,187,260	\$4,227	\$54,250	\$50,023		\$1,213,091	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 SIR Management	2011	\$2,858	\$352	\$404	\$52	5	\$566	76
77										77
78										78
79										79
80	TOTALS			\$2,858	\$352	\$404	\$52		\$566	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,345,183	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$114,827	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$321,236	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$206,409	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,923,911	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 11,648
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 111,436	\$		\$ 111,436	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			111,067			111,067	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			148,586			148,586	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				129,300		129,300	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					10,717	23,576		34,293	13
14	TOTAL			\$		\$ 381,806	\$ 152,876		\$ 534,682	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 71,161	\$ 95,941	1
2	Cash-Patient Deposits	117,950	117,950	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,520,333	2,520,333	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,588	60,588	6
7	Other Prepaid Expenses	101,826	1,826	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		30,427	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,871,858	\$ 2,827,065	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		517,253	13
14	Buildings, at Historical Cost		2,518,622	14
15	Leasehold Improvements, at Historical Cost	1,480,410	1,480,410	15
16	Equipment, at Historical Cost	1,423,620	2,032,620	16
17	Accumulated Depreciation (book methods)	(1,365,242)	(4,150,466)	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 (specify):			22
23	Other(specify): See Attached Schedule	115,449	115,449	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,654,237	\$ 2,513,888	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,526,095	\$ 5,340,953	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 672,900	\$ 856,924	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,034	59,034	28
29	Short-Term Notes Payable	1,475,000	1,475,000	29
30	Accrued Salaries Payable	332,125	332,125	30
31	Accrued Taxes Payable (excluding real estate taxes)	44,233	44,233	31
32	Accrued Real Estate Taxes(Sch.IX-B)		111,500	32
33	Accrued Interest Payable		29,127	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	80,552	80,552	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,663,844	\$ 2,988,495	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,862,440	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,862,440	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,663,844	\$ 11,850,935	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,862,251	\$ (6,509,982)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,526,095	\$ 5,340,953	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,539,608	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,539,608	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	563,843	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	(241,200)	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)	\$ 322,643	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,862,251	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,365,258	1
2	Discounts and Allowances for all Levels	(1,336,442)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,028,816	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,380,410	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,380,410	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	110,803	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,440	19
20	Radiology and X-Ray	5,373	20
21	Other Medical Services	8,261	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 135,877	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,639	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,639	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	41,135	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 41,135	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,591,877	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,606,642	31
32	Health Care	3,372,794	32
33	General Administration	2,100,663	33
	B. Capital Expense		
34	Ownership	1,040,110	34
	C. Ancillary Expense		
35	Special Cost Centers	534,682	35
36	Provider Participation Fee	373,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,028,034	40
41	Income before Income Taxes (line 30 minus line 40)**	563,843	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 563,843	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,705	2,847	\$ 114,273	\$ 40.14	1
2	Assistant Director of Nursing	1,803	1,900	63,053	33.19	2
3	Registered Nurses	19,731	20,770	646,970	31.15	3
4	Licensed Practical Nurses	12,914	13,593	329,364	24.23	4
5	CNAs & Orderlies	71,207	74,955	913,700	12.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,613	8,014	157,792	19.69	8
9	Activity Director	1,989	2,094	35,004	16.72	9
10	Activity Assistants	7,344	7,731	82,335	10.65	10
11	Social Service Workers	17,153	18,056	226,961	12.57	11
12	Dietician					12
13	Food Service Supervisor	1,991	2,096	37,996	18.13	13
14	Head Cook	7,452	7,844	83,543	10.65	14
15	Cook Helpers/Assistants	16,567	17,439	160,089	9.18	15
16	Dishwashers					16
17	Maintenance Workers	3,424	3,604	45,119	12.52	17
18	Housekeepers	26,693	28,098	263,843	9.39	18
19	Laundry	7,413	7,803	67,574	8.66	19
20	Administrator	1,970	2,074	89,743	43.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,837	19,829	248,654	12.54	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	5,157	5,428	157,253	28.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,161	2,161	8,904	4.12	33
34	TOTAL (lines 1 - 33)	234,124	246,336	\$ 3,732,170 *	\$ 15.15	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 18,048	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	4,592	10-03	37
38	Nurse Consultant	Monthly	48,720	10-03	38
39	Pharmacist Consultant	213	12,898	10-03	39
40	Physical Therapy Consultant	Monthly	32,575	10a-03	40
41	Occupational Therapy Consultant	Monthly	5,458	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	264	11,637	10a-03	43
44	Activity Consultant	Monthly	2,448	11-03	44
45	Social Service Consultant	Monthly	6,300	12-03	45
46	Other(specify)				46
47	Psychiatric Director	Monthly	7,200	12-03	47
48	Food Service Director	Monthly	24,360	1-3	48
49	TOTAL (lines 35 - 48)	477	\$ 181,436		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,490	\$ 153,877	10-03	50
51	Licensed Practical Nurses	3,262	132,011	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,752	\$ 285,888		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number				STATE OF ILLINOIS		Page 21			
Maplewood Care				#	0040428	Report Period Beginning:	01/01/11	Ending:	12/31/11
XIX. SUPPORT SCHEDULES									
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name		Function	Ownership %	Amount	Description		Amount	Description	
Jamie Lloyd		Administrator	0.00%	\$ 89,743	Workers' Compensation Insurance		\$ 88,512	IDPH License Fee	
					Unemployment Compensation Insurance		61,965	Advertising: Employee Recruitment	
					FICA Taxes		278,057	Health Care Worker Background Check	
					Employee Health Insurance		60,081	(Indicate # of checks performed 130)	
					Employee Meals		33,803	Patient Background Checks	
					Illinois Municipal Retirement Fund (IMRF)*			Advertising and Promotion	
					401K Matching		5,725	Dues and Subscriptions	
					Other Employee Benefits		9,085	License & Permits	
								Allocated from S.I.R. Management	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)				\$ 89,743				Less: Public Relations Expense	
B. Administrative - Other								Non-allowable advertising	
Description			Amount					Yellow page advertising	
SIR Management- Consulting Fees			\$ 445,613					TOTAL (agree to Sch. V,	
SIR Management- Director of Administrative Services			48,720					line 20, col. 8)	
SIR Management- Ancillary Administrative Charges			48,720						
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 543,053	TOTAL (agree to Schedule V,		\$ 537,228		
(Attach a copy of any management service agreement)					line 22, col.8)				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description	
See Attached		Legal	\$ 45,842					Out-of-State Travel	
SIR Management		Dir. Of Regulatory Services	24,360						
SIR Management		Accounting Fees	36,000						
Frost, Ruttenberg, & Rothblatt		Accounting Fees	19,789					In-State Travel	
SIR Management		Bookkeeping Fees	90,132						
Personnel Planners		Unemployment Tax Consult	2,111						
HDSI		Software Services	498						
MNS		Software Services	1,000					Seminar Expense	
Compliance Team		Code Consult.	769					Allocated from S.I.R. Management	
MDI		Software Services	1,037						
Honkamp Krueger & Co.		Tax Credit Consult	360						
See Supplemetal Schedule			10,508					Entertainment Expense	
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 232,405				line 24, col. 8)	
								\$ 8,436	
* Attach copy of IMRF notifications									
SEE ACCOUNTANTS' COMPILATION REPORT									
**See instructions.									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ICLTC \$17,270

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$2,561

Line10

(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?

X

YES

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.

\$373,143

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.

\$33,803

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?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' COMPILATION REPORT