

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 DriveElgin60123 County: Kane Telephone Number: (847) 697-3750Fax #: (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 X PROPRIETARY Individual Partnership Corporation X"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:

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

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

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>74,298</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>74,298</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>63,333</u>	<u>1,262</u>	<u>4,285</u>	<u>68,880</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,333</u>	<u>1,262</u>	<u>4,285</u>	<u>68,880</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.71%

D. How many bed-hold days during this year were paid by the Department? 632 (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 4/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 4/1/1993 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 3,201

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

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

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	291,662	24,670	42,761	359,093		359,093	(17,110)	341,983			1
2	Food Purchase		324,227		324,227	(32,512)	291,715	(59)	291,656			2
3	Housekeeping	271,705	58,921		330,626		330,626		330,626			3
4	Laundry	71,487	20,442		91,929		91,929		91,929			4
5	Heat and Other Utilities			180,491	180,491		180,491	(27,983)	152,508			5
6	Maintenance	55,050	36,817	181,538	273,405		273,405	(14,750)	258,655			6
7	Other (specify):*							5,241	5,241			7
8	TOTAL General Services	689,904	465,077	404,790	1,559,771	(32,512)	1,527,259	(54,661)	1,472,598			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,418,294	194,156	152,174	2,764,624		2,764,624	(27,067)	2,737,557			10
10a	Therapy	123,144	392	23,635	147,171		147,171	(11,375)	135,796			10a
11	Activities	112,142	17,453	2,244	131,839		131,839		131,839			11
12	Social Services	249,205		15,560	264,765		264,765		264,765			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,789	5,789			15
16	TOTAL Health Care and Programs	2,902,785	212,001	205,613	3,320,399		3,320,399	(32,653)	3,287,746			16
	C. General Administration											
17	Administrative	88,961		556,674	645,635		645,635	(448,001)	197,634			17
18	Directors Fees											18
19	Professional Services			207,573	207,573		207,573	(127,372)	80,201			19
20	Dues, Fees, Subscriptions & Promotions			49,534	49,534		49,534	(29,780)	19,754			20
21	Clerical & General Office Expenses	266,055	23,574	292,793	582,422		582,422	(86,292)	496,130			21
22	Employee Benefits & Payroll Taxes			570,568	570,568	32,512	603,080		603,080			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,359	4,359		4,359	379	4,738			24
25	Other Admin. Staff Transportation			7,980	7,980		7,980	9,943	17,923			25
26	Insurance-Prop.Liab.Malpractice			148,841	148,841		148,841	1,642	150,483			26
27	Other (specify):*							48,781	48,781			27
28	TOTAL General Administration	355,016	23,574	1,838,322	2,216,912	32,512	2,249,424	(630,699)	1,618,725			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,947,705	700,652	2,448,725	7,097,082		7,097,082	(718,013)	6,379,069			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			145,460	145,460		145,460	225,646	371,106			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,619	76,619		76,619	511,330	587,949			32
33	Real Estate Taxes							99,773	99,773			33
34	Rent-Facility & Grounds			960,000	960,000		960,000	(960,000)				34
35	Rent-Equipment & Vehicles			5,050	5,050		5,050	6,344	11,394			35
36	Other (specify):*							1	1			36
37	TOTAL Ownership			1,187,129	1,187,129		1,187,129	(116,907)	1,070,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,815	344,139	479,954		479,954		479,954			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			510,247	510,247		510,247		510,247			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		135,815	854,386	990,201		990,201		990,201			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,947,705	836,467	4,490,240	9,274,412		9,274,412	(834,920)	8,439,492			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	(30,432)	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	200,399	30		9
10	Interest and Other Investment Income	(74)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	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	(2,000)	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	(186,894)	21		24
25	Fund Raising, Advertising and Promotional	(5,986)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,998)	20		28
29	Other-Attach Schedule	(89,899)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (128,943)		\$	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)	(705,977)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (705,977)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (834,920)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Maplewood Care

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Collections	\$ (6,096)	19	1
2	Bank Fees	(5,944)	21	2
3	Lobbying	(433)	19	3
4	Theft & Damage	(2,620)	21	4
5	State Replacement Tax	(6,900)	21	5
6	Amort. Of Loan Fees - Building Co	(36,517)	36	6
7	Filing Fees - Building Co.	(275)	20	7
8	Office Expense - Building Co	(45)	21	8
9	Professional Fees - Building Co	(12,355)	19	9
10	Additional R&M	11,886	06	10
11	Capitalized R&M	(12,987)	06	11
12	Additional 2012 Seminar	105	24	12
13	COPE Dues	(8,280)	20	13
14	Non-allowable Legal Fees	(9,051)	19	14
15	P.P - Seminar	(90)	24	15
16	2013 Seminar Exp	(297)	24	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	(89,899)		49

Maplewood Care

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

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

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		Building 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	\$ 960,000	Maplewood-Jane, LLC	100.00%	\$	(960,000)	1
2	V	36	Amort. Of Loan Fees				36,518	36,518	2
3	V	30	Depreciation				15,895	15,895	3
4	V	20	Filing Fees				275	275	4
5	V	32	Interest Expense				512,813	512,813	5
6	V	21	Office Expense				45	45	6
7	V	19	Professional Fees				12,355	12,355	7
8	V	33	Real Estate Tax				106,400	106,400	8
9	V	33	Real Estate Tax Prior	10,326				(10,326)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 970,326			\$ 684,301	\$ * (286,025)	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%	\$ 8,962	\$ (15,398)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	702	702	16
17	V	10	NURSING	51,156	S.I.R. MANAGEMENT, INC.	100.00%	16,076	(35,080)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,704	2,704	18
19	V	19	PROFESSIONAL FEES	140,748	S.I.R. MANAGEMENT, INC.	100.00%	13,131	(127,617)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	484	484	20
21	V	21	CLERICAL & GENERAL	48,720	S.I.R. MANAGEMENT, INC.	100.00%	61,315	12,595	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	661	661	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,943	9,943	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,513	1,513	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,849	10,849	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(8,317)	(8,317)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,344	6,344	27
28	V								28
29	V	17	ADMINISTRATIVE	556,674	S.I.R. MANAGEMENT, INC.	100.00%	27,390	(529,284)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	226	226	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	103,396	103,396	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,208	20,208	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 821,658			\$ 275,587	\$ * (546,071)	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%	\$ 7,250	\$ (17,110)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,229	1,229	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,013	8,013	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,348	1,348	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	81,283	81,283	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	15,541	15,541	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	17,724	17,724	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	21,924	S.I.R. MANAGEMENT, INC.	100.00%	10,549	(11,375)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,737	1,737	25
26	V								26
27	V	6	MAINTENANCE SALARIES	17,020	S.I.R. MANAGEMENT, INC.	100.00%	18,200	1,180	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,310	3,310	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,449	2,449	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	569	569	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	58	58	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	75	75	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	129	129	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,352	9,352	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,908	6,908	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,699	3,699	37
38	V								38
39	Total			\$ 63,304			\$ 189,423	\$ * 126,119	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	\$	CCS Employee Benefits Group	100.00%	\$ 66,366	\$ 66,366	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	66,366	CCS Employee Benefits Group	100.00%		(66,366)	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			\$ 66,366			\$ 66,366	\$ *	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 (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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	CELESTE GIANNINI TRUST DTD 3/13/00	10.510%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	CHARLENE HILL -JEON	2.488%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	DANIEL ROTHNER TRUST	2.985%	DECATUR MANOR HEALTHCARE,LLC	DECATUR				5
6	DENNIS TOSSI	0.995%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	GALE ROTHNER	7.463%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				7
8	HARVEY SCOTT	0.995%	GREENWOOD CARE, INC.	EVANSTON				8
9	JEFF ORAVEC	0.498%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	JOEY ABRAMCHIK	2.488%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	JULIANA R. BARRISH TRUST DTD 1/26/93	12.998%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	KATHRYN VALES TRUST	2.985%	WILSON CARE, INC.	CHICAGO				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: 01/01/12 Ending: 12/31/12

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	Elka Abramchick	Relative	Clerical	N/A	See Attached	2.58	8.06%	Alloc. Salary	\$ 3,579	21-7	1
2	Joey Abramchik	Shareholder	Administrative	2.49	See Attached	3.63	8.07%	Alloc. Salary	15,541	17-7	2
3	Bryan Barrish	Relative	Administrative	N/A	See Attached	3.23	7.18%	Alloc. Salary	16,151	17-7	3
4	Kirsten Barrish	Relative	Clerical	N/A	See Attached	3.23	8.08%	Alloc. Salary	3,763	21-7	4
5	Sarah Barrish	Relative	Administrative	N/A	See Attached	4.04	8.08%	Alloc. Salary	9,766	17-7	5
6	Louise Bergthold	Shareholder	Administrative	5.97	See Attached	4.85	8.08%	Alloc. Salary	16,151	17-7	6
7	Michael Giannini	Relative	Administrative	N/A	See Attached	2.83	7.08%	Alloc. Salary	13,566	17-7	7
8	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.04	8.08%	Alloc. Salary	7,250	1-7	8
9	Jeff Oravec	Shareholder	Administrative	0.50	See Attached	3.23	8.08%	Alloc. Salary	11,240	17-7	9
10	Adam Vales	Relative	Clerical	N/A	See Attached	0.44	1.10%	Alloc. Salary	806	22-7	10
11	David Winter	Relative	Clerical	N/A	See Attached	0.52	8.00%	Alloc. Salary	273	21-7	11
12	See second page 7 for the detail of the additional owner and related compensation								16,221		12
13								TOTAL	\$ 114,307		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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	6	REPAIRS AND MAINT.	PATIENT DAYS	852,976	13	\$ 110,978	\$ 47,841	68,880	\$ 8,962	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		68,880	702	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	68,880	16,076	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		68,880	2,704	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	68,880	13,131	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		68,880	484	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	68,880	61,315	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		68,880	661	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		68,880	9,943	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		68,880	1,513	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		68,880	10,849	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		68,880	(8,317)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		68,880	6,344	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	68,880	27,390	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		68,880	226	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	68,880	103,396	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		68,880	20,208	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,412,714	\$ 2,543,620		\$ 275,587	25

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

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	852,976	13	\$ 89,778	\$ 89,778	68,880	\$ 7,250	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		68,880	1,229	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	68,880	8,013	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		68,880	1,348	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	68,880	81,283	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		68,880	15,541	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		68,880	17,724	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	21,924	10,549	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		21,924	1,737	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	17,020	18,200	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		17,020	3,310	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		1,040	2,449	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		1,040	569	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		1,040	58	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		1,040	75	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		1,040	129	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		1,040	9,352	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		1,040	6,908	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		1,040	3,699	23
24										24
25	TOTALS					\$ 2,596,289	\$ 1,763,707		\$ 189,423	25

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

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			\$	\$		\$ 66,366	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					\$	\$		\$ 66,366	25

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

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	Wells Fargo		X	Note Payable			\$	500,134			\$	3,856	1
2	Heartland Bank		X	Mortgage Payable				7,912,890				468,608	2
3	Shareholder Loan		X	Note Payable				800,000				44,205	3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				950,000				72,763	6
7	Alloc. S.I.R. Management	X										6,908	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	10,163,024			\$	596,340	9
	B. Non-Facility Related*												
10	Interest Income		X									(74)	10
11	Alloc. S.I.R. Management	X										(8,317)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(8,391)	14
15	TOTALS (line 9+line14)						\$	10,163,024			\$	587,949	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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 2011 report.				\$	111,500	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.)				\$	104,873	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(6,627)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	106,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
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.				\$	99,773	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2007	95,557	8		
		2008	96,692	9		
		2009	102,344	10		
		2010	106,031	11		
		2011	101,174	12		
2012 Accrual = \$101,174 x 1.05 = 106,400 (Rounded)						
Allocated from S.I.R Management = \$3,699						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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>
---------------	-----------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-15-304-015</u>	<u>Long-Term Care Property</u>	\$ <u>101,173.74</u>	\$ <u>101,173.74</u>
2. <u>Home Office Allocation</u>	<u>See Attached</u>	\$ <u>101,165.17</u>	\$ <u>6,397.80</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>202,338.91</u></u>	\$ <u><u>107,571.54</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

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? _____ YES _____ NO

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).

[illegible]

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	Facility			\$ 517,253	1
2					2
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	203		1993	1972	\$ 5,445,306	\$ 15,895	35	\$ 155,580	\$ 139,685	\$ 3,030,204
5										
6										
7										
8										
	Improvement Type**									
9	Various		1993		98,204		20	1,792	1,792	66,274
10	Various		1994		13,684		20	684	684	13,260
11	Various		1995		5,179		20	259	259	4,522
12	Various		1996		19,800		20	990	990	16,665
13	Various		1997		21,688		20	1,084	1,084	17,188
14	Various		1998		19,077		20	954	954	13,627
15	Various		1999		35,671		20	1,625	1,625	21,825
16	Various		2000		330,225		20	16,511	16,511	210,635
17	Various		2001		72,848		20	2,918	2,918	50,348
18	Various		2002		15,524		20	486	486	12,995
19	Various		2003		22,349		20	1,117	1,117	10,738
20	Various		2004		18,088		20	1,099	1,099	9,178
21	Various		2005		114,777		20	5,739	5,739	42,803
22	Various		2006		278,330		20	13,917	13,917	90,774
23	Various		2007		37,791		20	1,890	1,890	10,708
24	Various		2008		148,040		20	12,353	12,353	55,357
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	157,701	4,922		6,043	1,121	71,740	68
69	Financial Statement Depreciation		145,460			(145,460)		69
70	TOTAL (lines 4 thru 69)	\$ 6,854,282	\$ 166,277		\$ 225,041	\$ 58,764	\$ 3,748,841	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:

01/01/12

Ending:

12/31/12

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		\$ 6,854,282	\$ 166,277		\$ 225,041	\$ 58,764	\$ 3,748,841	1
2	Bathrooms- Plumbing, Walls, Tiles, Electrical, New Fixtures	2009	27,600		20	1,380	1,380	5,520	2
3	Pavers	2009	14,800		20	740	740	2,343	3
4	Hvac Compressor & Contactor	2009	2,873		20	144	144	515	4
5	Hvac Compressor	2009	2,831		20	142	142	507	5
6	Master Key System	2009	2,915		20	146	146	510	6
7	Hvac Compressor	2009	3,430		20	172	172	586	7
8	Heat Exchanger	2009	2,978		20	149	149	484	8
9	Rooftop Hvac Units	2009	20,370		20	2,037	2,037	6,281	9
10	Window Treatments	2010	9,999		20	2,000	2,000	5,000	10
11	Nurse Stations	2010	44,761		20	8,952	8,952	23,127	11
12	Replace Door	2010	2,745		20	137	137	366	12
13	Compressor Repair	2010	3,129		20	156	156	391	13
14	Compressor Repair	2010	2,860		20	143	143	369	14
15	Hallway Room Signs	2011	6,855		20	686	686	1,085	15
16	Elevator Hydraulic Pump	2011	9,082		20	454	454	719	16
17	Elevator Interior Work	2011	10,070		20	504	504	839	17
18	Flooring & Wall-Base	2011	5,752		20	288	288	431	18
19	Ceiling Grid	2011	34,930		20	1,747	1,747	2,765	19
20	Wallcoverings	2011	3,616		20	723	723	1,145	20
21	Window Treatments	2011	14,156		20	708	708	1,062	21
22	Water Heater	2011	4,306		20	215	215	305	22
23	Handrails, Crashrails, Corner Guards	2011	76,093		20	3,805	3,805	4,756	23
24	Hvac Rooftop Unit	2011	20,964		20	1,048	1,048	1,398	24
25	Painting	2011	51,280		20	2,564	2,564	2,991	25
26	Wallpaper	2011	83,106		20	8,311	8,311	9,696	26
27	Flooring, Wallbase, Wallcoverings	2011	56,318		20	2,816	2,816	4,459	27
28	Wallcoverings	2011	4,314		20	216	216	324	28
29	Painting	2011	5,675		20	284	284	497	29
30	Landscaping - Sedum Autumn Joy, Stella De Oro, Shredded Hard	2011	2,866		20	143	143	239	30
31	Landscaping - Boxwood, Black Eyed Susan, Campanula White Cli	2011	7,954		20	398	398	630	31
32	Heat Exchanger # 9 Replacement	2011	2,817		20	141	141	164	32
33	Heat Exchanger #8 Replacement	2011	2,991		20	150	150	174	33
34	TOTAL (lines 1 thru 33)		\$ 7,398,718	\$ 166,277		\$ 266,536	\$ 100,259	\$ 3,828,518	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:

01/01/12

Ending:

12/31/12

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		\$ 7,398,718	\$ 166,277		\$ 266,536	\$ 100,259	\$ 3,828,518	1
2	Partial Blower Replacement 400 Wing	2011	2,559		20	128	128	256	2
3	New Corner Guards	2011	4,301		20	215	215	251	3
4	Heating & Cooling Repairs	2011	2,659		20	133	133	199	4
5	Domestic Hot Water System	2011	3,328		20	166	166	333	5
6	Flooring For 1St Floor Resident Rooms	2011	67,137		20	3,357	3,357	6,714	6
7	Built-In Custom Cabinets, Built-In Closer Wardrobe With Crown	2012	94,860		20	2,767	2,767	2,767	7
8	Furnish And Install Microprocessor Controller, Tape Selector	2012	42,300		20	1,234	1,234	1,234	8
9	Upgraded Cubicle Curtains For 1St Floor	2012	17,664		20	368	368	368	9
10	Hvac Unit	2012	10,807		20	135	135	135	10
11	Sprinkler Heads	2012	4,350		20	54	54	54	11
12	Renovate Fire Doors	2012	6,392		20	186	186	186	12
13	Flooring - 1St Floor Rooms	2012	9,192		20	383	383	383	13
14	Flooring For 1St Floor Resident Rooms	2012	83,080		20	4,154	4,154	4,154	14
15	First Floor Karndean Wood Look Hallway Tile	2012	73,402		20	3,670	3,670	3,670	15
16	First Floor Karndean Wood Look Hallway Tile	2012	64,822		20	3,241	3,241	3,241	16
17	Sprinkler Heads	2012	5,622		20	283	283	283	17
18	Heating & Cooling - Compressor	2012	3,430		20	172	172	172	18
19	Leonard Mixing Station	2012	3,935		20	197	197	197	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)		\$ 7,898,558	\$ 166,277		\$ 287,379	\$ 121,102	\$ 3,853,115	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 12C, Carried Forward		\$ 7,898,558	\$ 166,277		\$ 287,379	\$ 121,102	\$ 3,853,115	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)		\$ 7,898,558	\$ 166,277		\$ 287,379	\$ 121,102	\$ 3,853,115	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		\$ 7,898,558	\$ 166,277		\$ 287,379	\$ 121,102	\$ 3,853,115	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)		\$ 7,898,558	\$ 166,277		\$ 287,379	\$ 121,102	\$ 3,853,115	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								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:

01/01/12

Ending:

12/31/12

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	Allocated - S.I.R. Management	2009	20,188		39	518	518	1,574	3
4	Allocated- S.I.R. Properties - S.I.R. Management	1993	36,553	1,160	35	1,044	(116)	20,365	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - S.I.R. Management	1993	9,267	258	20	459	201	9,189	9
10	Allocated - S.I.R. Management	1994	29		20			29	10
11	Allocated - S.I.R. Management	1995	212		20	11	11	184	11
12	Allocated - S.I.R. Management	1997	14,240	319	20	699	380	11,229	12
13	Allocated - S.I.R. Management	1999	1,120		20	56	56	741	13
14	Allocated - S.I.R. Management	1999	11,357		20			11,357	14
15	Allocated - S.I.R. Management	2000	1,322		20	66	66	829	15
16	Allocated - S.I.R. Management	2007	4,248	290	20	212	(78)	1,103	16
17	Allocated - S.I.R. Management	2008	11,706	1,118	20	738	(380)	3,574	17
18	Allocated - S.I.R. Management	2009	29,087	266	20	1,454	1,188	4,719	18
19	Allocated - S.I.R. Management	2011	720	72	20	72		102	19
20	Allocated - S.I.R. Management	2012	2,303	48	20	48		48	20
21									21
22	Allocated- S.I.R. Properties - S.I.R. Management	2012	2,239	1,191	20	10	(1,181)	10	22
23	Allocated- S.I.R. Properties - S.I.R. Management	2010	2,206		20	110	110	257	23
24	Allocated- S.I.R. Properties - S.I.R. Management	2009	2,195	137	20	110	(27)	417	24
25	Allocated- S.I.R. Properties - S.I.R. Management	2007	640	51	20	32	(19)	192	25
26	Allocated- S.I.R. Properties - S.I.R. Management	2002	145		20	7	7	76	26
27	Allocated- S.I.R. Properties - S.I.R. Management	1999	4,632		20	232	232	3,126	27
28	Allocated- S.I.R. Properties - S.I.R. Management	1998	2,213		20	111	111	1,605	28
29	Allocated- S.I.R. Properties - S.I.R. Management	1997	138		20	7	7	114	29
30	Allocated- S.I.R. Properties - S.I.R. Management	1994	348	9	20	17	8	322	30
31	Allocated- S.I.R. Properties - S.I.R. Management	1993	593	3	20	30	27	578	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								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)	\$ 157,701	\$ 4,922		\$ 6,043	\$ 1,121	\$ 71,740	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	\$540,751	\$3,864	\$67,022	\$63,158	10	\$633,905	71
72	Current Year Purchases	253,446	163	16,273	16,110	10	16,273	72
73	Fully Depreciated Assets	645,862				10	645,862	73
74								74
75	TOTALS	\$1,440,059	\$4,027	\$83,295	\$79,268		\$1,296,040	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 S.I.R. Management	2011	\$2,839	\$402	\$431	\$29	5	\$993
77									
78									
79									
80	TOTALS			\$2,839	\$402	\$431	\$29		\$993

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)			\$9,858,709
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$170,706
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$371,105
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$200,399
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$5,150,148

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Legat	\$176,690
93	Urban Contractor Doors	10,189
94	Offices	10,710
95		\$197,589

* 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: \$ 11,394
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 106,678	\$		\$ 106,678	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			111,619			111,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			121,964			121,964	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				111,618		111,618	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					3,878	24,197		28,075	13
14	TOTAL			\$		\$ 344,139	\$ 135,815		\$ 479,954	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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 25,303	\$ 45,646	1
2	Cash-Patient Deposits	74,876	74,876	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,989,595	1,989,595	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,758	59,758	6
7	Other Prepaid Expenses	3,818	3,818	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,153,350	\$ 2,173,693	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	1,922,378	1,922,378	15
16	Equipment, at Historical Cost	1,716,353	2,325,353	16
17	Accumulated Depreciation (book methods)	(1,510,702)	(4,311,821)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		77,448	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	202,308	202,308	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,330,337	\$ 3,251,541	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,483,687	\$ 5,425,234	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 241,401	\$ 379,419	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	74,888	74,888	28
29	Short-Term Notes Payable	950,000	950,000	29
30	Accrued Salaries Payable	401,715	401,715	30
31	Accrued Taxes Payable (excluding real estate taxes)	59,217	59,217	31
32	Accrued Real Estate Taxes(Sch.IX-B)		106,400	32
33	Accrued Interest Payable		20,196	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	235,670	235,670	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,962,891	\$ 2,227,505	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	500,134	1,300,134	39
40	Mortgage Payable		7,912,890	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)	\$ 500,134	\$ 9,213,024	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,463,025	\$ 11,440,529	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,020,662	\$ (6,015,295)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,483,687	\$ 5,425,234	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,862,251	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,862,252	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	449,860	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	(291,450)	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)	\$ 158,410	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,020,662	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			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,509,853	1
2	Discounts and Allowances for all Levels	(1,277,584)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,232,269	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,221,900	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,221,900	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	110,172	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,810	19
20	Radiology and X-Ray	7,065	20
21	Other Medical Services	23,221	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 143,268	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	74	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 74	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	126,761	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 126,761	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,724,272	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,559,771	31
32	Health Care	3,320,399	32
33	General Administration	2,216,912	33
	B. Capital Expense		
34	Ownership	1,187,129	34
	C. Ancillary Expense		
35	Special Cost Centers	479,954	35
36	Provider Participation Fee	510,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,274,412	40
41	Income before Income Taxes (line 30 minus line 40)**	449,860	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 449,860	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,576,429	44
45	Private Pay - Net Inpatient Revenue	186,374	45
46	Medicare - Net Inpatient Revenue	331,897	46
47	Other-(specify) Hospice	121,113	47
48	Other-(specify) HMO/Insurance	16,456	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,232,269	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,875	2,940	\$ 119,797	\$ 40.75	1
2	Assistant Director of Nursing	1,931	1,965	69,494	35.37	2
3	Registered Nurses	25,779	27,184	861,588	31.69	3
4	Licensed Practical Nurses	9,549	10,525	261,852	24.88	4
5	CNAs & Orderlies	79,248	80,514	974,136	12.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,984	7,447	123,144	16.54	8
9	Activity Director	1,731	1,922	33,058	17.20	9
10	Activity Assistants	8,949	9,198	79,084	8.60	10
11	Social Service Workers	17,266	18,398	240,350	13.06	11
12	Dietician					12
13	Food Service Supervisor	1,818	2,083	39,173	18.81	13
14	Head Cook	5,781	6,324	71,780	11.35	14
15	Cook Helpers/Assistants	17,586	19,014	180,709	9.50	15
16	Dishwashers					16
17	Maintenance Workers	4,101	4,285	55,050	12.85	17
18	Housekeepers	27,216	28,489	271,705	9.54	18
19	Laundry	7,460	7,843	71,487	9.11	19
20	Administrator	1,801	2,091	88,961	42.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,033	20,832	266,055	12.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,415	4,825	131,427	27.24	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,147	2,147	8,855	4.12	33
34	TOTAL (lines 1 - 33)	245,670	258,026	\$ 3,947,705 *	\$ 15.30	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	\$ 18,401	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Monthly	4,608	10-03	37
38	Nurse Consultant	Monthly	51,156	10-03	38
39	Pharmacist Consultant	207	12,543	10-03	39
40	Physical Therapy Consultant	Monthly	21,924	10a-03	40
41	Occupational Therapy Consultant	Monthly	409	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	30	1,302	10a-03	43
44	Activity Consultant	Monthly	2,244	11-03	44
45	Social Service Consultant	Monthly	8,360	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	7,200	12-03	47
48	Director of Food Service	Monthly	24,360	01-03	48
49	TOTAL (lines 35 - 48)	237	\$ 164,507		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	955	\$ 43,607	10-03	50
51	Licensed Practical Nurses	795	34,622	10-03	51
52	Certified Nurse Assistants/Aides	133	5,638	10-03	52
53	TOTAL (lines 50 - 52)	1,883	\$ 83,867		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: 01/01/12	
						Ending: 12/31/12	
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	Amount
Jamie Lloyd	Administrator	0.0%	\$ 88,961	Workers' Compensation Insurance	\$ 84,925	IDPH License Fee	\$ 1,988
				Unemployment Compensation Insurance	102,136	Advertising: Employee Recruitment	3,041
				FICA Taxes	294,753	Health Care Worker Background Check	5,106
				Employee Health Insurance	68,661	(Indicate # of checks performed 520)	
				Employee Meals	32,512	Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	925
				401K Matching	6,675	ICLTC	15,042
				Other Employee Benefits	13,418	License & Permits	1,448
TOTAL (agree to Schedule V, line 17, col. 1)						Advertising & Promotion	19,984
(List each licensed administrator separately.)			\$ 88,961			See Supplemental Schedule	484
B. Administrative - Other						Less: Public Relations Expense	(8,280)
Description			Amount			Non-allowable advertising	(5,986)
SIR Management- Consulting Fees			\$ 453,834			Yellow page advertising	(13,998)
SIR Management- Director of Administrative Services			48,720				
SIR Management - Ancillary Administrative Charges			54,120				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 556,674	TOTAL (agree to Schedule V, line 22, col.8)	\$ 603,080	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description
Vendor/Payee	Type		Amount				Amount
SIR Management	Dir. Reggulatory Services		\$ 24,360				Out-of-State Travel
SIR Management	Accounting Fees		36,000				
SIR Management	Bookkeeping		80,388				
Plante Moran	401K Consulting		1,444				In-State Travel
FR&R	Accounting Fees		21,074				
See Attached	Legal		16,861				
Personnel Planners	Unemployment Consulting		2,415				
Pinnacle	Customer Satisfaction		3,841				Seminar Expense
eHealth Data	MDS Software		3,600				Allocated from S.I.R. Management
HK Payroll Services	WOTC Consulting		360				
Compliance Team	Code Consulting		600				
See Supplemental Schedule			16,630				Entertainment Expense
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 207,573			TOTAL	\$ 4,738
				* Attach copy of IMRF notifications		**See instructions.	
SEE ACCOUNTANTS' COMPILATION REPORT							

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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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 \$15,042
- (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. \$ 2,590 Line 10
- (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. \$ 510,247
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. \$ 32,512 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 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