

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0051839

Facility Name: Maple Crest Care Centre

Address: 4452 Squaw Prairie Belvidere 61008
Number City Zip Code

County: Boone

Telephone Number: (815) 547-6377 Fax # (815) 547-3857

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2012

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) RSM US LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Maple Crest Care Centre

0051839 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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>86</u>	Skilled (SNF)	<u>86</u>	<u>31,476</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>86</u>	TOTALS	<u>86</u>	<u>31,476</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>15,973</u>	<u>7,639</u>	<u>6,252</u>	<u>29,864</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>15,973</u>	<u>7,639</u>	<u>6,252</u>	<u>29,864</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.88%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/31/2011 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 86 and days of care provided 4,626

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	192,801	22,820	7,828	223,449		223,449		223,449			1
2	Food Purchase		162,324		162,324		162,324		162,324			2
3	Housekeeping	66,961	27,067		94,028		94,028		94,028			3
4	Laundry	48,055	11,263	3,667	62,985		62,985		62,985			4
5	Heat and Other Utilities			88,315	88,315		88,315	890	89,205			5
6	Maintenance	72,924	705	130,270	203,899		203,899	9,993	213,892			6
7	Other (specify):* Mgmt alloc of benef							1,459	1,459			7
8	TOTAL General Services	380,741	224,179	230,080	835,000		835,000	12,342	847,342			8
	B. Health Care and Programs											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	1,880,241	104,114	23,010	2,007,365		2,007,365	56,116	2,063,481			10
10a	Therapy	16,990			16,990		16,990		16,990			10a
11	Activities	69,627		7,694	77,321		77,321		77,321			11
12	Social Services	40,205		1,001	41,206		41,206		41,206			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							8,712	8,712			15
16	TOTAL Health Care and Programs	2,007,063	104,114	54,505	2,165,682		2,165,682	64,828	2,230,510			16
	C. General Administration											
17	Administrative	132,833		377,154	509,987		509,987	(361,168)	148,819			17
18	Directors Fees											18
19	Professional Services			161,348	161,348		161,348	(22,305)	139,043			19
20	Dues, Fees, Subscriptions & Promotions			21,799	21,799		21,799	4,214	26,013			20
21	Clerical & General Office Expenses	77,549	16,930	32,347	126,826		126,826	136,745	263,571			21
22	Employee Benefits & Payroll Taxes			444,400	444,400		444,400		444,400			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,406	3,406		3,406	560	3,966			24
25	Other Admin. Staff Transportation			4,337	4,337		4,337	230	4,567			25
26	Insurance-Prop.Liab.Malpractice			174,594	174,594		174,594	1,512	176,106			26
27	Other (specify):* Mgmt alloc of benef							20,135	20,135			27
28	TOTAL General Administration	210,382	16,930	1,219,385	1,446,697		1,446,697	(220,077)	1,226,620			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,598,186	345,223	1,503,970	4,447,379		4,447,379	(142,907)	4,304,472			29

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

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

V. COST CENTER EXPENSES (continued)

	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			54,270	54,270		54,270	1,314	55,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,745	1,745			32
33	Real Estate Taxes			59,153	59,153		59,153	1,987	61,140			33
34	Rent-Facility & Grounds			920,184	920,184		920,184	2,720	922,904			34
35	Rent-Equipment & Vehicles			36,045	36,045		36,045	2,518	38,563			35
36	Other (specify):*											36
37	TOTAL Ownership			1,069,652	1,069,652		1,069,652	10,284	1,079,936			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,334	2,334		2,334		2,334			38
39	Ancillary Service Centers		130,919	842,849	973,768		973,768		973,768			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,365	200,365		200,365		200,365			42
43	Other (specify):* Non-Allowable Cos	82,931		235,226	318,157		318,157	(318,157)				43
44	TOTAL Special Cost Centers	82,931	130,919	1,280,774	1,494,624		1,494,624	(318,157)	1,176,467			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,681,117	476,142	3,854,396	7,011,655		7,011,655	(450,780)	6,560,875			45

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

VI. ADJUSTMENT DETAIL

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

	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	(5,977)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,149)	30		9
10	Interest and Other Investment Income	(384)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,352)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,249)	43		18
19	Entertainment				19
20	Contributions	(14,474)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,532)	43		24
25	Fund Raising, Advertising and Promotional	(5,378)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(199,382)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (360,877)		\$	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)	(89,903)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (89,903)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (450,780)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (11,027)	43	1
2	Laboratory Costs	(9,786)	43	2
3	X-Ray Costs	(10,854)	43	3
4	Nonallowable Legal Expense	(17,534)	19	4
5	Lobbying expense	(2,435)	20	5
6	Marketing Travel	(1,063)	25	6
7	Marketing Consultants	(43,597)	43	7
8	Nonallowable collection fees	(20,155)	19	8
9	Community Relations	(61,258)	43	9
10	Guest Relations	(21,673)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(199,382)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V	N/A							3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ * 0	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services-Other	\$ 828	Symphony Financial Services, LLC	100%	\$	(828)	15
16	V	21	Clerical & Gen office exp		Symphony Financial Services, LLC	100%	18,642	18,642	16
17	V	24	Travel & Seminar		Symphony Financial Services, LLC	100%	38	38	17
18	V	30	Depreciation		Symphony Financial Services, LLC	100%	1,664	1,664	18
19	V	32	Interest		Symphony Financial Services, LLC	100%	2,129	2,129	19
20	V	34	Rent - Facility & Grounds		Symphony Financial Services, LLC	100%	127	127	20
21	V	35	Rent - Equipment		Symphony Financial Services, LLC	100%	1	1	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			\$ 828			\$ 22,601	\$ * 21,773	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	<u>Utilities</u>	\$	<u>Maestro Consulting Services</u>	100%	\$ 890	\$ 890	15
16	V	6	<u>Maintenance Salaries</u>		<u>Maestro Consulting Services</u>	100%	8,147	8,147	16
17	V	6	<u>Maintenance Expenses</u>		<u>Maestro Consulting Services</u>	100%	1,846	1,846	17
18	V	7	<u>Employee Benefits - Maintenance</u>		<u>Maestro Consulting Services</u>	100%	1,459	1,459	18
19	V	10	<u>Clinical Salaries</u>		<u>Maestro Consulting Services</u>	100%	56,116	56,116	19
20	V	15	<u>Employee Benefits - Clinical</u>		<u>Maestro Consulting Services</u>	100%	8,712	8,712	20
21	V	17	<u>Administrative Salaries</u>	377,154	<u>Maestro Consulting Services</u>	100%	15,986	(361,168)	21
22	V	19	<u>Professional Fees</u>		<u>Maestro Consulting Services</u>	100%	16,212	16,212	22
23	V	20	<u>Dues, Fees, Subscriptions, Etc.</u>		<u>Maestro Consulting Services</u>	100%	6,649	6,649	23
24	V	21	<u>Clerical & General Salaries</u>		<u>Maestro Consulting Services</u>	100%	105,025	105,025	24
25	V	21	<u>Clerical & General Expenses</u>		<u>Maestro Consulting Services</u>	100%	13,078	13,078	25
26	V	24	<u>Seminars & Education</u>		<u>Maestro Consulting Services</u>	100%	522	522	26
27	V	25	<u>Transportation</u>		<u>Maestro Consulting Services</u>	100%	1,293	1,293	27
28	V	26	<u>Insurance</u>		<u>Maestro Consulting Services</u>	100%	1,512	1,512	28
29	V	27	<u>Employee Benefits - Administrative</u>		<u>Maestro Consulting Services</u>	100%	20,135	20,135	29
30	V	30	<u>Depreciation</u>		<u>Maestro Consulting Services</u>	100%	799	799	30
31	V	33	<u>Real Estate Tax</u>		<u>Maestro Consulting Services</u>	100%	1,987	1,987	31
32	V	34	<u>Building Rental</u>		<u>Maestro Consulting Services</u>	100%	2,593	2,593	32
33	V	35	<u>Equipment Rental</u>		<u>Maestro Consulting Services</u>	100%	1,121	1,121	33
34	V	35	<u>Auto Lease</u>		<u>Maestro Consulting Services</u>	100%	1,396	1,396	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 377,154			\$ 265,478	\$ * (111,676)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 2,416	Integra Healthcare Equipment, LLC		\$ 2,416	\$	15
16	V	35	Rent-Equipment & Vehicles	6,274	Integra Healthcare Equipment, LLC		6,274		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			\$ 8,690			\$ 8,690	\$ * 0	39

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

Facility Name & ID Number

Maple Crest Care Centre

0051839

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony of	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony of	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cres	Belvidere	Maestro Consulting Se	Lincolnwood	Mgmt. Co.	5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				8
9	Joseph Hartman	3.00	Symphony Evanston Healthcare	Evanston				9
10	David J. Hartman	20.00	Symphony of Dyer	Indiana				10
11	Jay Flatt	3.00	Symphony of Crown Point	Indiana	Nucare Services	Lincolnwood	Bookkeeping Mgmt	11
12	Gerry Jenich	10.00	Symphony of Chesterton	Indiana	7257 N. Lincoln Ave, I	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00			Diamond Insurance	Northbrook	Work Comp Ins.	13
14					Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			California Gardens Corp.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Monroe Pavillion	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Sycamore Village	Swansea	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Symphony of Aria	Hillside	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Symphony at 87th Street	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Symphony at Midway	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Symphony at Tillers	Oswego	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Symphony at Bronzeville	Chicago	Lifemed Pharmacy	Bensenville	Pharmacy	22
23			Symphony of Buffalo Grove	Buffalo Grove	ConcertoHealth	Chicago	Clinical Services	23
24			Symphony of Chicago West	Chicago				24
25			Symphony of Glendale	Glendale, Wiscosin	* No expense paid by home to the related			25
26			Symphony of Hanover Park	Hanover Park	entity, therefore no page 6 or 8.			26
27			Symphony of Lincoln Park	Chicago	** No expense of this related business			27
28			Symphony of Morgan Park	Chicago	allocated to homes			28
29			Symphony of South Shore	Chicago				29
30			Symphony Residences of Lincoln Park	Chicago				30

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	No owners receive compensation from this facility.			0.00					\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 Symphony Financial Services, LLC
Street Address 7257 N. Lincoln Ave,
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 933-2600
Fax Number ()

	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	19	Professional Services-Other	Occupied Bed Days	502,430	12	\$ (13,929)	\$	29,864	\$ (828)	1
2	21	Clerical & Gen office exp	Occupied Bed Days	502,430	12	313,631		29,864	18,642	2
3	24	Travel & Seminar	Occupied Bed Days	502,430	12	638		29,864	38	3
4	30	Depreciation	Occupied Bed Days	502,430	12	28,003		29,864	1,664	4
5	32	Interest	Occupied Bed Days	502,430	12	35,825		29,864	2,129	5
6	34	Rent - Facility & Grounds	Occupied Bed Days	502,430	12	2,143		29,864	127	6
7	35	Rent - Equipment	Occupied Bed Days	502,430	12	14		29,864	1	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					\$ 366,325	\$		\$ 21,773	25

Facility Name & ID Number Maple Crest Care Centre# 0051839

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Maestro Consulting Services

Street Address

7257 N. Lincoln Ave,

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 933-2600

Fax Number

()

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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	5	Utilities	Bed Days Available	28	\$ 51,919	\$	31,476	\$ 890	1
2	6	Maintenance Salaries	Bed Days Available	28	475,288	475,288	31,476	8,147	2
3	6	Maintenance Expenses	Bed Days Available	28	107,711		31,476	1,846	3
4	7	Employee Benefits - Maintenance	Bed Days Available	28	85,090		31,476	1,459	4
5	10	Clinical Salaries	Bed Days Available	28	3,273,643	3,273,643	31,476	56,116	5
6	15	Employee Benefits - Clinical	Bed Days Available	28	508,220		31,476	8,712	6
7	17	Administrative Salaries	Bed Days Available	28	932,558	932,558	31,476	15,986	7
8	19	Professional Fees	Bed Days Available	28	945,768		31,476	16,212	8
9	20	Dues, Fees, Subscriptions, Etc.	Bed Days Available	28	387,900		31,476	6,649	9
10	21	Clerical & General Salaries	Bed Days Available	28	6,126,863	6,126,863	31,476	105,025	10
11	21	Clerical & General Expenses	Bed Days Available	28	762,920		31,476	13,078	11
12	24	Seminars & Education	Bed Days Available	28	30,439		31,476	522	12
13	25	Transportation	Bed Days Available	28	75,434		31,476	1,293	13
14	26	Insurance	Bed Days Available	28	88,214		31,476	1,512	14
15	27	Employee Benefits - Administrative	Bed Days Available	28	1,174,614		31,476	20,135	15
16	30	Depreciation	Bed Days Available	28	46,621		31,476	799	16
17	33	Real Estate Tax	Bed Days Available	28	115,912		31,476	1,987	17
18	34	Building Rental	Bed Days Available	28	151,288		31,476	2,593	18
19	35	Equipment Rental	Bed Days Available	28	65,399		31,476	1,121	19
20	35	Auto Lease	Bed Days Available	28	81,453		31,476	1,396	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 15,487,254	\$ 10,808,352		\$ 265,478	25

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Integra Healthcare Equipment, LLC
Street Address 747 Church Road
City / State / Zip Code Elmhurst, IL 60126
Phone Number (630) 834-3700
Fax Number (630) 834-1500

	1 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	10	Nursing and Medical Records	Direct Allocation		\$	\$		\$ 2,416	1
	2	35	Rent-Equipment & Vehicles	Direct Allocation					6,274	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				\$	\$		\$ 8,690	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							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	17,520,000	(2,040,567)	4/22/2017	0.0450		6
7												7
8												8
9	TOTAL Facility Related						\$ 17,520,000	\$ (2,040,567)			\$	9
	B. Non-Facility Related*											
10												10
11												11
12								Offset Interest Income			(384)	12
13								Allocated from Mgmt Co.			2,129	13
14	TOTAL Non-Facility Related						\$				\$ 1,745	14
15	TOTALS (line 9+line14)						\$ 17,520,000	\$ (2,040,567)			\$ 1,745	15

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

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

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

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

B. Real Estate Taxes

		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 2015 report.				\$	55,400 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.)		2015		\$	56,341 2
3. Under or (over) accrual (line 2 minus line 1).				\$	941 3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	58,212 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.			Alloc. Fr. Mgmt Co.		1,987
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.				\$	61,140 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	44,123	8	
		2012	49,772	9	
		2013	50,908	10	
		2014	52,744	11	
		2015	56,341	12	
2016 Tax Accrual = \$56,341 * 1.03 = 58,031; Use \$58,212					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$		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.

FACILITY NAME	<u>Symphony Maple Crest, LLC D/B/A Maple Crest Care Centre</u>	COUNTY	<u>Boone</u>
---------------	--	--------	--------------

CONTACT PERSON REGARDING THIS REPORT David Davis

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

A. Square Feet: 36,000

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Alloc Fr Maestro 7257		2004	\$ 2,743	1
2					2
3	TOTALS			\$ 2,743	3

Facility Name & ID Number Maple Crest Care Centre

0051839

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8	Allocated from Maestro 7257		2004		24,684		39	633	633	9,257
	Improvement Type**									
9	F&I Smoke Detector above fire alarm control panel in		2013		3,725	186	20	186		745
10	100 Wing Nurse Station									
11										
12	Facility Remodeling		2014		396,750	19,838	20	19,838		53,580
13	-Demo/carpentry/drywall throughout facility									
14	-Railing throughout facility									
15	-Pulled wires for lights, rough in & installed can lights in									
16	200 Wing Spa									
17	-Rough in fire place area, rough in floor box in									
18	200 Wing Spa									
19	-Hallway, restrooms, dining room & recreation room -									
20	remove wallpaper & prep wall									
21	-Spa wall and floor tile in salon									
22	-Plumbing work done in salon									
23	-Electrical throughout facility									
24	-Interior painting in resident rooms, front offices,									
25	reception area and therapy room									
26	-Floor coverings throughout facility									
27	-Vestibule work									
28	-Automatic doors throughout Facility									
29	-Permits									
30	-Gazebo outside									
31	-Architectural services									
32	-General contractors fees									
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Maple Crest Care Centre

0051839

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Architecture fee, Electric power for new entrance door	2015	\$ 10,187	\$ 510	20	\$ 510	\$	\$ 934	37
38	Repair broken drain pipe, Kitchen floor	2015	4,995	249	20	249		416	38
39	Dark bronze glass and aluminum door and frame	2015	19,144	957	20	957		1,037	39
40	-1 dining room, 1 end of 100 Hallway (LTC) and 200 Hallway								40
41									41
42	Installed electrical work: new conduit, trench and back fill from	2016	3,910	114	20	114		114	42
43	the main valve to the back of the building, fire wire to main fire panel								43
44									44
45	Allocated from Maestro Consulting Services	2003	201		39			132	45
46	Allocated from Maestro Consulting Services	2004	4,076		39			2,593	46
47	Allocated from Maestro Consulting Services	2005	242		39			143	47
48	Allocated from Maestro Consulting Services	2006	328		39			170	48
49	Allocated from Maestro Consulting Services	2008	345		39			143	49
50	Allocated from Maestro Consulting Services	2009	5,561		20			2,116	50
51	Allocated from Maestro Consulting Services	2010	855		20			278	51
52	Allocated from Maestro Consulting Services	2011	46		20			14	52
53	Allocated from Maestro Consulting Services	2012	51		20			12	53
54	Allocated from Maestro Consulting Services	2014	643		20			84	54
55	Allocated from Maestro Consulting Services	2015	181		20			12	55
56	Allocated from Maestro Consulting Services	2016	792		20	31	31	31	56
57									57
58									58
59	Allocated from Maestro 7257	2004	491		10			307	59
60	Allocated from Maestro 7257	2005	2,250		10	16	16	1,569	60
61	Allocated from Maestro 7257	2015	389		15	37	37	35	61
62									62
63									63
64	Tie to book Depreciation			1,149			(1,149)		64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 479,846	\$ 23,003		\$ 22,571	\$ (432)	\$ 73,722	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$152,153	\$27,397	\$27,396	\$ (1)	5-7	\$92,523	71
72	Current Year Purchases	34,686	3,870	3,870	-	5	3,870	72
73	Fully Depreciated Assets				-			73
74	See Sch 13A	40,536	-	1,747	1,747		35,543	74
75	TOTALS	\$227,375	\$31,267	\$33,013	\$1,746		\$131,936	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Maestro Consulting Services			\$152	\$	\$	\$-		\$152	76
77					-	-	-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			\$152	\$-	\$-	\$-		\$152	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$710,116	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$54,270	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$55,584	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,314	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$205,810	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name: Maple Crest Care Centre
IDPH License ID Number: 0051839
Fiscal Year End: 12/31/2016

Schedule 13A

XI. Ownership Costs
Line 74 - Equipment Costs - Excluding Transportation

Category of				Current Book	Straight Line		Component	Accumulated
Equipment	Cost			Depreciation	Depreciation	Adjustments	Life	Depreciation
Allocated from Symphony Financial Services, LLC		10,182			1,664	1,664	5-7	5,750
Allocated from Maestro Consulting Services		30,354			83	83	5-10	29,793
						-		
TOTAL		40,536		-	1,747	1,747		35,543

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. X 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:	1972	86	12/31/2011	\$ 918,646	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				2720			6
7	TOTAL		86		\$ 921,366			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

1,538
15,379

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

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

15. Is Movable equipment rental included in building rental?

YES X NO

16. Rental Amount for movable equipment: \$ 34,759 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2016 Van	\$ 482	\$ 2,408	17
18					18
19					19
20	Allocated from Mgmt. Co.			1,396	20
21	TOTAL		\$ 482.00	\$ 3,804	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.	/2017	\$ 636,725
13.	/2018	\$ 649,460
14.	/2019	\$ 662,449

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

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

Facility Name:

Maple Crest Care Centre

IDPH License ID Number:

0051839

Fiscal Year End:

12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
E Tank Regulator	2,609
Blood Pressure Machine	2,376
Dish Machine	2,134
Printer	9,784
Computer	1,079
Office Equipment	5,975
E Cylinder	18
Concentrators	1,227
Negative Pressure Wound	6,294
Compressor High Output	3
Equipment Lease - Scales	1,536
Pipe-in music service on office phones	508
Voice Media	94
HO Allocation	1,122
Total - Line 16	34,759

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	5,351	\$ 385,258	\$	5,351	\$ 385,258	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		591	42,546		591	42,546	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,617	404,442		5,617	404,442	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				125,043		125,043	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)			147	10,603		147	10,603	12
13	Other (specify): Oxygen	39(2)					5,876		5,876	13
14	TOTAL			\$	11,706	\$ 842,849	\$ 130,919	11,706	\$ 973,768	14

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

Facility Name: Maple Crest Care Centre
IDPH License ID Number: 0051839
Fiscal Year End: 12/31/2016

Schedule 16A

XIV. Special Services (Direct Cost)

Line 12 Other (specify)

Description	Units	Amount
INHALATION THERAPY-PRIVATE		54
INHALATION THERAPY-MEDICARE		3,370
INHALATION THERAPY-MEDICAID		261
INHALATION THERAPY-MANAGED CARE		882
I.V. THERAPY-MEDICARE		3,699
INHALATION THERAPY-PRIVATE		25
INHALATION THERAPY-MEDICARE		561
INHALATION THERAPY-MEDICAID		494
INHALATION THERAPY-PENDING		48
OTHER OUTSIDE SERV-PENDING		1,209
Total - Line 12	-	10,603

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	\$ 22,718	\$ 22,718	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 181,634)	1,769,488	1,769,488	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,873	21,873	6
7	Other Prepaid Expenses	31,951	31,951	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	2,089,014	2,089,014	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,935,044	\$ 3,935,044	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,743	13
14	Buildings, at Historical Cost		24,684	14
15	Leasehold Improvements, at Historical Cost	461,626	455,162	15
16	Equipment, at Historical Cost	186,838	227,527	16
17	Accumulated Depreciation (book methods)	(156,661)	(205,810)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Lease cost, net	7,689	7,689	22
23	Other(specify): See Schedule 17A	860,372	860,372	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,359,864	\$ 1,372,367	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,294,908	\$ 5,307,411	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,202,461	\$ 1,202,461	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,952	127,952	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,212	58,212	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,767,729	1,767,729	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,156,354	\$ 3,156,354	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,156,354	\$ 3,156,354	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,138,554	\$ 2,151,057	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,294,908	\$ 5,307,411	48

*(See instructions.)

Facility Name: Maple Crest Care Centre
IDPH License ID Number: 0051839
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After
		Consolidation
Reserve for Capex	48,447	48,447
Refundable Overpayment - A/P	2,040,567	2,040,567
Total - Line 9	2,089,014	2,089,014

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After
		Consolidation
Security Deposit	90,862	90,862
Real Estate Escrow Deposit	162,386	162,386
Due T/F Affiliated Companies	607,124	607,124
Total - Line 23	860,372	860,372

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

Description	Operating	After
		Consolidation
EXCHANGE FORMATION L/H	432,709	432,709
SECURITY DEPOSIT PAYABLE	-	-
OPERATING EXPENSES	67,347	67,347
MANAGEMENT FEES - SYMPHONY	124,701	124,701
INS. WRKS DEDUCT/SETTLEMENT	170,257	170,257
STATE UNEMPLOYMENT TAX	3,340	3,340
FEDERAL UNEMPLOYMENT TAX	601	601
SALES TAX	607	607
PAYROLL TAXES OTHER	12,420	12,420
ACCRUED EMPLOYEE BENEFITS	123,977	123,977
FICA & W/H FED	21	21
DUE TO IDPA - BED TAX	24,353	24,353
DUE TO KENSINGTON GROUP	190,923	190,923
EXCHANGE	9,608	9,608
WAGE ASSIGNMENTS-GARNISHMENTS	577	577
PATIENT PERSONAL FUNDS	5,280	5,280
DUE TO MAESTRO - EXPENSES	60,097	60,097
DUE T/F AFFILIATED COMPANY - HEALTHCARE INSURANCE	177,438	177,438
DUE T/F AFFILIATED COMPANY - RENT	70,829	70,829
DEFERRED RENT	343,070	343,070
ACCUMULATED AMORTIZATION DEFERRED RENT	(50,426)	(50,426)
Total - Line 36	1,767,729	1,767,729

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,749,711	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(73,366)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,676,345	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	462,209	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 462,209	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)	\$ 2,138,554	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maple Crest Care Centre

0051839

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 7,189,504	1
2	Discounts and Allowances for all Levels	(1,622,581)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,566,923	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,662,825	6
7	Oxygen	898	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,663,723	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	176,289	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,018	19
20	Radiology and X-Ray	7,792	20
21	Other Medical Services	12,782	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 242,881	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	384	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 384	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(47)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (47)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,473,864	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	835,000	31
32	Health Care	2,165,682	32
33	General Administration	1,446,697	33
	B. Capital Expense		
34	Ownership	1,069,652	34
	C. Ancillary Expense		
35	Special Cost Centers	1,294,259	35
36	Provider Participation Fee	200,365	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,011,655	40
41	Income before Income Taxes (line 30 minus line 40)**	462,209	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 462,209	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,586,260	44
45	Private Pay - Net Inpatient Revenue	1,143,105	45
46	Medicare - Net Inpatient Revenue	1,200,679	46
47	Other-(specify) <u>Hospice</u>	340,760	47
48	Other-(specify) <u>Managed Care</u>	296,119	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,566,923	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

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

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

^ - Tax return prepared on cash basis

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,987	2,150	\$ 101,258	\$ 47.10	1
2	Assistant Director of Nursing	3,111	3,318	108,066	32.57	2
3	Registered Nurses	15,328	15,983	448,595	28.07	3
4	Licensed Practical Nurses	15,864	17,246	428,205	24.83	4
5	CNAs & Orderlies	56,193	59,791	773,210	12.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,015	1,142	16,990	14.88	8
9	Activity Director	1,817	1,903	30,770	16.17	9
10	Activity Assistants	3,605	3,974	38,857	9.78	10
11	Social Service Workers	1,955	2,146	40,205	18.73	11
12	Dietician					12
13	Food Service Supervisor	4,844	5,388	141,421	26.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,146	4,437	51,380	11.58	15
16	Dishwashers					16
17	Maintenance Workers	3,710	4,022	72,924	18.13	17
18	Housekeepers	7,378	7,727	66,961	8.67	18
19	Laundry	5,019	5,425	48,055	8.86	19
20	Administrator	2,000	2,185	132,833	60.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,442	3,770	82,931	22.00	23
24	Clerical	3,077	3,330	77,549	23.29	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	960	1,099	20,907	19.02	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,451	145,036	\$ 2,681,117 *	\$ 18.49	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	\$ 7,828	1(3)	35
36	Medical Director	Monthly	22,800	9(3)	36
37	Medical Records Consultant	Monthly	2,286	10(3)	37
38	Nurse Consultant	Monthly	3,834	10(3)	38
39	Pharmacist Consultant	Monthly	16,292	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,514	11(3)	44
45	Social Service Consultant	Monthly	1,001	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,555		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Renee Woods	Administrator	0	\$ 132,833	Workers' Compensation Insurance		\$ 93,639	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance		33,265	Advertising: Employee Recruitment	2,688	
				FICA Taxes		196,209	Health Care Worker Background Check		
				Employee Health Insurance		109,661	(Indicate # of checks performed 281)	3,371	
				Employee Meals			Patient Background Checks 263	3,150	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees	690	
				Employee Retirement		3,908	Illinois Council on Long Term Care	7,379	
				Employee Benefits - Other		3,154	Miscellaneous Dues & Subscriptions	4,521	
				Employees' Physical Exams		4,564	Lobbying offset	(2,435)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Allocated from Mgmt. Co.	6,649	
							Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
							TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 26,013		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			G. Schedule of Travel and Seminar**		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Schedule 21C			\$ 161,348	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	3,406	
							Allocated from Mgmt. Co.	560	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL \$ 3,966		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Maple Crest Care Centre
IDPH License ID Number: 0051839
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Ability Network	Secure Exchange Managed Services	5,587
Allscripts	Quarterly Referral Management Core Integration	2,529
Barracuda Networks	Cude Sign Cloud	157
Carbonite, Inc	Protect One Services	2,280
Cardmember Service (Mileage Plus) - Joliet	MRC -Inbox Local/Usage Inbound & Outbound	258
CDW Government	Airwatch Renewal	342
Comcast Business	Internet	35,305
Constant Care Technology	Care Connection	1,703
Corporate Service Company	Annual Filing	480
Creative Technology	IT Support	7,264
Dart Chart Map and Track Systems, LLC - JOL	Mapping of HMO Contract Specification Sets	99
Documentation Solutions Inc	Legal Fees	506
eFax Corporate	MRC -Inbox Local/Usage Inbound & Outbound	285
EMMI Solutions	Subscription - Engage Provider	56
Empower Retirement	PPA Re-Statement Fee	32
Evault Inc	Protect One Services	456
Formation Healthcare Group	Monthly Subscription Fee	488
Frontier	Internet	540
FYI Systems, Inc	Alteryx Services	183
HDSI	Data Processing	4,124
Health Data Systems Inc	Programming	246
Health Dimensions Group	Consulting Services	389
Hipp Law Office	Legal Fees	17,534
HK Payroll Services	Work Tax Credit	2,080
IIT/SourceTech	Operator Monthly Support Fee	1,380
Intermedia Marketing Solutions	Sale/Surveys/Partial Surveys	227
Kipp Computer Solution	HP5800/HP6000 Upgrade	200
Language Line Service	Phone Interpretation	37
Maestro Consulting Services	Consulting Services	37,919
Market Matrix	Customer and Employee Metrix Subscription	3,298
Medical Business Office	Collection Agency	14,481
Microsoft Corporation	Micro Software	1,750
Moeo	SPAN iOS + Android App V2 (Family Connection)	109
Moobile	New Dev Iteration/Updates on Multiple Recipients & Security	88
Pension Financial Services Inc	Symphony Multiple Employer Plan	277
Personnel Planners Inc	Qtrly Unemployment Claims	1,125
PointB Communication	Yrly Web Hosting	220
Prime Care Technologies	PBJ Reporting Module Access Fee	60
Qualfon	Sale/Surveys/Partial Surveys	130
Resolute	Collection Agency	5,674
RSM US LLP	Accounting	18,196
Stone Pogrund & Korey	Legal Fees	2,670
Stone, McGuire & Siegel	Legal Fees	14,452
Symphony Post Acute	Administrative Consultant	(50,000)
Telemedicine Solutions LLC	Wound Rounds Care	8,419
Ventiv Technology Inc.	RiskConsole Services	996
Wescom Solutions	Data Processing	16,585
Zirmed	Eligibility Verification	132
Total (agree to Schedule V, line 19, column 3)		161,348
Allocated from Management CompanyProfessional Services		15,384
Less: Non-Allowable Legal Fees		(17,534)
Less: Professional Collections Fees		(20,155)
Total (agree to Schedule V, line 19, column 8)		139,043

XX. GENERAL INFORMATION:

- | | |
|---|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>IL Council LTC - \$7,379</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>5-7 Yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>0</u> Line <u>10(2)</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
<u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>200,365</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>5</u>
d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>No</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>RSM US LLP</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees</p> |
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