FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051839

Facility Name: Maple Crest Care Centre

Address: 4452 SquawPrairie Rd (Number) Belvidere (City) 61008 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 01/01/2014 to 12/31/2014 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) McGladrey 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: 01/01/2014 Ending: 12/31/2014

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,897	5,897	8
9	SNF/PED					9
10	ICF	14,732	7,087	456	22,275	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,732	7,087	6,353	28,172	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.75%

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 [X] 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 [X]

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 [X] Date 12/31/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 86 and days of care provided 4,940

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,193	13,850	8,033	217,076		217,076		217,076			1
2	Food Purchase		155,991		155,991		155,991		155,991			2
3	Housekeeping	66,534	23,956		90,490		90,490		90,490			3
4	Laundry	54,157	15,352	2,775	72,284		72,284		72,284			4
5	Heat and Other Utilities			105,573	105,573		105,573	346	105,919			5
6	Maintenance	71,427	64	125,577	197,068		197,068	3,183	200,251			6
7	Other (specify):*											7
8	**TOTAL General Services**	387,311	209,213	241,958	838,482		838,482	3,529	842,011			8
	B. Health Care and Programs											
9	Medical Director			26,640	26,640		26,640		26,640			9
10	Nursing and Medical Records	1,606,484	80,396	10,085	1,696,965		1,696,965	26,104	1,723,069			10
10a	Therapy	29,940			29,940		29,940		29,940			10a
11	Activities	62,706		11,817	74,523		74,523		74,523			11
12	Social Services	36,094		2,226	38,320		38,320		38,320			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt alloc of benef							5,215	5,215			15
16	**TOTAL Health Care and Programs**	1,735,224	80,396	50,768	1,866,388		1,866,388	31,319	1,897,707			16
	C. General Administration											
17	Administrative	99,895		311,155	411,050		411,050	(311,155)	99,895			17
18	Directors Fees											18
19	Professional Services			171,593	171,593		171,593	11,932	183,525			19
20	Dues, Fees, Subscriptions & Promotions			21,974	21,974		21,974	(1,136)	20,838			20
21	Clerical & General Office Expenses	235,774	22,194	36,149	294,117		294,117	58,636	352,753			21
22	Employee Benefits & Payroll Taxes			384,735	384,735		384,735		384,735			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,620	4,620		4,620	7,721	12,341			24
25	Other Admin. Staff Transportation			5,333	5,333		5,333	(3,351)	1,982			25
26	Insurance-Prop.Liab.Malpractice			205,246	205,246		205,246	4,313	209,559			26
27	Other (specify):* Mgmt alloc of benef							15,195	15,195			27
28	**TOTAL General Administration**	335,669	22,194	1,140,805	1,498,668		1,498,668	(217,845)	1,280,823			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,458,204	311,803	1,433,531	4,203,538		4,203,538	(182,997)	4,020,541			29

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

Facility Name & ID Number Maple Crest Care Centre #0051839 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,653	39,653		39,653	2,187	41,840			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,620	8,620		8,620	(4,260)	4,360			32
33	Real Estate Taxes			52,088	52,088		52,088		52,088			33
34	Rent-Facility & Grounds			789,800	789,800		789,800	(68,933)	720,867			34
35	Rent-Equipment & Vehicles			42,758	42,758		42,758	1,928	44,686			35
36	Other (specify):*											36
37	**TOTAL Ownership**			932,919	932,919		932,919	(69,078)	863,841			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,706	7,706		7,706		7,706			38
39	Ancillary Service Centers		145,113	832,313	977,426		977,426		977,426			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			188,103	188,103		188,103		188,103			42
43	Other (specify):* **Non-Allowable Cos**			173,051	173,051		173,051	(173,051)				43
44	**TOTAL Special Cost Centers**		145,113	1,201,173	1,346,286		1,346,286	(173,051)	1,173,235			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,458,204	456,916	3,567,623	6,482,743		6,482,743	(425,126)	6,057,617			45

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(4,295)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,260)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,368)	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	(2,661)	43		18
19	Entertainment				19
20	Contributions	(4,231)	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	(103,718)	43		24
25	Fund Raising, Advertising and Promotional	(8,866)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(154)	43		28
29	Other-Attach Schedule See Page 5A	(103,787)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (233,340)		$	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)	(191,786)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (191,786)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (425,126)		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

Maple Crest Care Centre

ID# 0051839

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (30,274)	43	1
2	Laboratory Costs	(8,384)	43	2
3	X-Ray Costs	(8,385)	43	3
4	Nonallowable Legal Expense	(1,429)	43	4
5	Lobbying expense	(2,844)	20	5
6	Other Services	(715)	43	6
7	Admitting Salaries	(48,405)	21	7
8	Marketing Travel	(3,351)	25	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(103,787)		49

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Symphony Financial Services, LLC	100.00%	$ 346	$ 346	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	3,183	3,183	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	26,104	26,104	17
18	V	15	Other		Symphony Financial Services, LLC	100.00%	5,215	5,215	18
19	V	17	Administrative	311,155	Symphony Financial Services, LLC	100.00%		(311,155)	19
20	V	19	Professional Services		Symphony Financial Services, LLC	100.00%	13,361	13,361	20
21	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	1,708	1,708	21
22	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	107,041	107,041	22
23	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	7,721	7,721	23
24	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	4,313	4,313	24
25	V	27	Other		Symphony Financial Services, LLC	100.00%	15,195	15,195	25
26	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	2,187	2,187	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(68,933)	(68,933)	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	1,928	1,928	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			$ 311,155			$ 119,369	$ * (191,786)	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: 01/01/2014 Ending: 12/31/2014

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 o	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony o	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere				5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	Nucare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7257 N. Lincoln Ave, L	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Claremont - Hanover Park	Hanover Park	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at Park South	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona	* No expense paid by home to the related			24
25			Renaissance West	Mesa, Arizona	entity, therefore no page 6 or 8.			25
26			Renaissance Village IL	Mesa, Arizona	** No expense of this related business			26
27			Renaissance Village AL	Mesa, Arizona	allocated to homes			27
28								28
29								29
30								30

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	
						Hours	Percent	Description	Amount		
1	No owners receive compensation from this facility.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 [X] 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 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	5	Utilities	Occupied Bed Days	418,769	8	$ 5,138	$	28,172	$ 346	1
2	6	Maintenance	Occupied Bed Days	418,769	8	47,313		28,172	3,183	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	418,769	8	388,030	388,030	28,172	26,104	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	77,521		28,172	5,215	4
5	19	Professional Services-Legal	Occupied Bed Days	418,769	8	14,326		28,172	964	5
6	19	Professional Services-Other	Occupied Bed Days	418,769	8	184,271		28,172	12,397	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	418,769	8	25,386		28,172	1,708	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	1,490,276	1,490,276	28,172	100,256	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	100,854		28,172	6,785	9
10	24	Travel & Seminar	Occupied Bed Days	418,769	8	114,768		28,172	7,721	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	418,769	8	64,109		28,172	4,313	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	225,869		28,172	15,195	12
13	30	Depreciation	Occupied Bed Days	418,769	8	32,512		28,172	2,187	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	418,769	8	(1,024,677)		28,172	(68,933)	14
15	35	Rent - Equipment	Occupied Bed Days	418,769	8	17,271		28,172	1,162	15
16	35	Rent - Vehicles	Occupied Bed Days	418,769	8	11,389		28,172	766	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,774,356	$ 1,878,306		$ 119,369	25

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	242,451	12/30/15	0.0550	8,620	6
7												7
8												8
9	TOTAL Facility Related						$ 17,520,000	$ 242,451			$ 8,620	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(4,260)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,260)	14
15	TOTALS (line 9+line14)						$ 17,520,000	$ 242,451			$ 4,360	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.)**

Facility Name & ID Number Maple Crest Care Centre # 0051839 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 52,320	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.)	2013	$ 50,908	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,412)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 53,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	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.		$ 52,088	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	51,151	8
	2010	54,125	9
	2011	44,123	10
	2012	49,772	11
	2013	50,908	12

2014 Tax Accural = $50,908 * 1.05 = 53,453; Use $53,500

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Maple Crest Care Centre COUNTY Boone

FACILITY IDPH LICENSE NUMBER 0051839

CONTACT PERSON REGARDING THIS REPORT Elizabeth Koshy

TELEPHONE (847) 745-6205 FAX #: (847) 673-2284

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-14-100-015	Nursing Home	$ 50,908.00	$ 50,908.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,908.00	$ 50,908.00

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 X _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	F&I Smoke Detector above fire alarm control panel in			2013	3,725	187	20	187		317	9
10	100 Wing Nurse Station										10
11											11
12	Facility Remodeling			2014	395,662	15,051	20	15,051		15,051	12
13	-Demo/carpentry/drywall throughout facility										13
14	-Railing throughout facility										14
15	-Pulled wires for lights, rough in & installed can lights in										15
16	200 Wing Spa										16
17	-Rough in fire place area, rough in floor box in										17
18	200 Wing Spa										18
19	-Hallway, restrooms, dining room & recreation room -										19
20	remove wallpaper & prep wall										20
21	-Spa wall and floor tile in salon										21
22	-Plumbing work done in salon										22
23	-Electrical throughout facility										23
24	-Interior painting in resident rooms, front offices,										24
25	reception area and therapy room										25
26	-Floor coverings throughout facility										26
27	-Vestibule work										27
28	-Automatic doors throughout Facility										28
29	-Permits										29
30	-Gazebo outside										30
31	-Architectural services										31
32	-General contractors fees										32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 399,387	$ 15,238		$ 15,238	$	$ 15,368	70

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 110,294	$ 20,060	$ 20,060	$	5-7	$ 33,659	71
72	Current Year Purchases	37,736	4,355	4,355		5-7	4,355	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co.	11,965		2,187	2,187		3,284	74
75	TOTALS	$ 159,995	$ 24,415	$ 26,602	$ 2,187		$ 41,298	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 559,382	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,653	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 41,840	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,187	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 56,666	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 & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 788,262	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				(68,933)			6
7	TOTAL		86		$ 719,329 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 1,538
   This amount was calculated by dividing the total amount to be amortized 15,379
   by the length of the lease 10 .

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

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.	/2015	$ 612,000
13.	/2016	$ 624,000
14.	/2017	$ 636,725

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: $ 43,727 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	Administrative		$	$ 193	17
18					18
19					19
20	Allocated from Mgmt. Co.			766	20
21	TOTAL		$	$ 959	21

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

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

Facility Name: **Maple Crest Care Centre**
IDPH License ID Number: **0051839**
Fiscal Year End: **12/31/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Mattress	3,535
VAC Freedom	15,512
E Tank Regulator	182
Blood Pressure Machine	2,376
Dish Machine	2,036
Helium	49
Room Temp Cooler	360
Copier	14,725
Computer	1,079
Sound System	585
Office Equipment	1,610
Broda Chair	30
Convectoin Oven	485
HO Allocation	1,162
Total - Line 16	**43,727**

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] 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)	$			

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	

(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.

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	4,684	$ 337,249	$	4,684	$ 337,249	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,125	80,975		1,125	80,975	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,286	380,564		5,286	380,564	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				138,878		138,878	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)				33,525			33,525	12
13	Other (specify): Oxygen	39(2)					6,235		6,235	13
14	TOTAL			$	11,095	$ 832,313	$ 145,113	11,095	$ 977,426	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: **12/31/2014**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description	Units	Amount
INHALATION THERAPY-MEDICAID		1,132
INHALATION THERAPY-MEDICARE		14,729
INHALATION THERAPY-MANAGED CARE		3,147
INHALATION THERAPY-PRIVATE		1,199
INHALATION THERAPY-MEDICARE		6,121
INHALATION THERAPY-MEDICAID		5,560
INHALATION THERAPY-PENDING		1,387
RESPIRATORY		250
Total - Line 12	**-**	**33,525**

STATE OF ILLINOIS

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 105,272	$ 105,272	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 224,808)	1,630,250	1,630,250	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,097	1,097	6
7	Other Prepaid Expenses	90,766	90,766	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,827,385	$ 1,827,385	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	423,390	399,387	15
16	Equipment, at Historical Cost	148,031	159,995	16
17	Accumulated Depreciation (book methods)	(53,438)	(56,666)	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 (spe Lease cost, net	10,765	10,765	22
23	Other(specify): Deposits	216,355	216,355	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 745,103	$ 729,836	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,572,488	$ 2,557,221	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 459,427	$ 459,427	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,589	92,589	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,500	53,500	32
33	Accrued Interest Payable	98	98	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	662,743	662,743	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,268,357	$ 1,268,357	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	242,451	242,451	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)**	$ 242,451	$ 242,451	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,510,808	$ 1,510,808	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,061,680	$ 1,046,413	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,572,488	$ 2,557,221	48

***(See instructions.)**

Facility Name: **Maple Crest Care Centre**
IDPH License ID Number: **0051839**
Fiscal Year End: **12/31/2014**

Schedule 17A

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

Description	Operating	After Consolidation
Exchange Formation L/H	310,820	310,820
Security Deposit Payable	11,142	11,142
Operating Expenses	62,659	62,659
Management Fees - Symphony	20,274	20,274
Ins. Wrks Deduct/Settlement	68,560	68,560
Accumulated Amortization Def	(4,108)	(4,108)
State Unemployment Tax	4,169	4,169
Federal Unemployment Tax	472	472
Sales Tax	518	518
Payroll Taxes Other	9,662	9,662
Accrued Employee Benefits	120,137	120,137
FICA & W/H Fed	242	242
Due to IDPA-Add'tl Bed Tax	24,013	24,013
Due to Kensington Group	17,684	17,684
Due to Nucare	9,608	9,608
Wage Assignments - Garnishment	616	616
Patient Personal Funds	6,275	6,275
Total - Line 36	**662,743**	**662,743**

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 626,511	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	750	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 627,261	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	434,419	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)**	$ 434,419	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,061,680	24	*

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,632,632	1
2	Discounts and Allowances for all Levels	(1,586,588)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,046,044	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,580,545	6
7	Oxygen	11,192	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,591,737	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	182,707	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,442	19
20	Radiology and X-Ray	3,889	20
21	Other Medical Services	55,062	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 275,100	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,260	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,260	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicare and Managed Care Rentals	21	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,917,162	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	838,482	31
32	Health Care	1,866,388	32
33	General Administration	1,498,668	33
	B. Capital Expense		
34	Ownership	932,919	34
	C. Ancillary Expense		
35	Special Cost Centers	1,158,183	35
36	Provider Participation Fee	188,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,482,743	40
41	**Income before Income Taxes (line 30 minus line 40)****	434,419	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 434,419	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,305,404	44
45	Private Pay - Net Inpatient Revenue	1,174,017	45
46	Medicare - Net Inpatient Revenue	1,351,099	46
47	Other-(specify) Hospice	76,228	47
48	Other-(specify) Managed Care	139,296	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,046,044	49

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

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

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

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

^ **Tax return prepared on cash basis.**

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,756	3,266	$ 129,309	$ 39.59	1
2	Assistant Director of Nursing	1,912	2,003	65,039	32.47	2
3	Registered Nurses	11,290	12,451	356,927	28.67	3
4	Licensed Practical Nurses	12,763	14,424	364,600	25.28	4
5	CNAs & Orderlies	53,233	58,181	690,609	11.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,916	2,085	29,940	14.36	8
9	Activity Director	3,988	4,480	62,706	14.00	9
10	Activity Assistants					10
11	Social Service Workers	1,617	1,966	36,094	18.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,296	21,850	195,193	8.93	15
16	Dishwashers					16
17	Maintenance Workers	4,223	4,742	71,427	15.06	17
18	Housekeepers	7,157	7,664	66,534	8.68	18
19	Laundry	5,593	6,125	54,157	8.84	19
20	Administrator	2,008	2,442	99,895	40.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,342	2,578	48,405	18.78	23
24	Clerical	6,594	8,527	187,369	21.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,688	152,784	$ 2,458,204 *	$ 16.09	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,033	1(3)	35
36	Medical Director	Monthly	26,640	9(3)	36
37	Medical Records Consultant	Monthly	1,768	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,317	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	2,181	11(3)	44
45	Social Service Consultant	Monthly	2,226	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 49,165		49

C. CONTRACT NURSES

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judith Wright	Administrator	0	$ 80,664
Renee Woods	Administrator	0	19,231
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,895

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Col. 7)	$ 311,155
TOTAL (agree to Schedule V, line 17, col. 3)	$ 311,155
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 171,593
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 171,593

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,755
Unemployment Compensation Insurance	37,826
FICA Taxes	182,018
Employee Health Insurance	85,634
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	12,471
Employee Benefits - Other	4,783
Employees' Physical Exams	2,248
TOTAL (agree to Schedule V, line 22, col.8)	$ 384,735

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,702
Health Care Worker Background Check	
(Indicate # of checks performed 213)	2,550
Patient Background Checks 83	1,000
Miscellaneous Licenses & Fees	1,005
Illinois Council on Long Term Care	8,617
Miscellaneous Dues & Subscriptions	5,110
Lobbying offset	(2,844)
Allocated from Mgmt. Co.	1,708
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,838

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,620
Allocated from Home Office	7,721
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,341

**See instructions.

Facility Name: **Maple Crest Care Centre**
IDPH License ID Number: **0051839**
Fiscal Year End: **12/31/2014**

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Hipp Law Office	Legal Fees	1,429
Much Shelist	Legal Fees	994
Stone, McGuire & Siegel	Legal Fees	15,087
Ability Network Inc	Secure Exchange Managed Services	1,938
AON E Solutions Inc	Risk Management Software/Maint	1,716
BOA - M. Hartman	Web Hosting	16
Comcast	Internet	29,633
Creative Tech Solutions	IT Support	7,233
Ehalth Data Solutions	Carewatch Billing	4,780
Evault Inc	Protect One Services	2,725
HDSI	Data Processing	3,123
HK Payroll Services	Work Tax Credit	96
IIT/SourceTech	Operator Monthly Support Fee	1,380
JP Graphics	SEO Improvements	49
Market Matrix	Customer/employee/social metrix	593
McGladrey LLP	Accounting	17,557
Moeo	CMS and API	148
Personnel Planners Inc	Qtrly Unemployment Claims	1,600
Pinnacle Quality	Customer Satisfaction	2,310
Point B Communication	Yrly Web Hosting	863
Provinent Solutions	Outsourced IT Services	552
Symphony Financial	Profession Fees	42,275
Telemedicine Solutions	Wound Rounds Care	8,419
Tonic Healthcare Resources, LLC	Fees for placement	13,912
Wescom Solutions	Data Processing	12,933
Zirmed	Eligibility Verification	232

Total (agree to Schedule V, line 19, column 3)	171,593
Allocated from Management Company Legal Fees	964
Allocated from Management Company Professional Services	12,397
Less: Non-Allowable Legal Fees	(1,429)
Total (agree to Schedule V, line 19, column 8)	183,525

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

Facility Name & ID Number Maple Crest Care Centre # 0051839 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council LTC - $5,773**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes - ICLTC $5,774**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **Yes**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 Yr**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **188** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **188,103**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ ____
c. What percent of all travel expense relates to transportation of nurses and patients? **5**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.