FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 0054627

Facility Name: Maple Crossing at Amboy

Address: 15 West Wasson Road (Number) Amboy (City) 61310 (Zip Code)

County: Lee

Telephone Number: (815) 857-2550 **Fax #** (815) 857-4016

HFS ID Number:

Date of Initial License for Current Owners: 7/1/2017

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 7/01/2017 to 12/31/2017 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 UP 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 Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	97	Skilled (SNF)	97	17,848	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	97	TOTALS	97	17,848	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		485	1,096	1,581	8
9	SNF/PED					9
10	ICF	5,123	2,802	2,361	10,286	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,123	3,287	3,457	11,867	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.49%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 [X] 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 6/8/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/8/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 1,096

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	77,950	8,720	379	87,049		87,049	-	87,049			1
2	Food Purchase		69,337		69,337		69,337	(5,988)	63,349			2
3	Housekeeping	62,863	16,483	-	79,346		79,346	31	79,377			3
4	Laundry	20,658	3,611	-	24,269	-	24,269	-	24,269			4
5	Heat and Other Utilities			42,595	42,595		42,595	-	42,595			5
6	Maintenance	28,018	20,390	3,756	52,164		52,164	532	52,696			6
7	Other (specify):*	-	-	-	-		-	-	-			7
8	**TOTAL General Services**	189,489	118,541	46,730	354,760	-	354,760	(5,425)	349,335			8
	B. Health Care and Programs											
9	Medical Director	-	-	1,495	1,495		1,495	-	1,495			9
10	Nursing and Medical Records	747,514	35,644	11,620	794,778		794,778	-	794,778			10
10a	Therapy	-	-	-	-		-	-	-			10a
11	Activities	23,648	1,315	-	24,963		24,963	-	24,963			11
12	Social Services	19,612	-	-	19,612		19,612	-	19,612			12
13	CNA Training	-	-	-	-		-	-	-			13
14	Program Transportation	-	-	-	-		-	-	-			14
15	Other (specify):*	-	-	-	-		-	-	-			15
16	**TOTAL Health Care and Programs**	790,774	36,959	13,115	840,848	-	840,848	-	840,848			16
	C. General Administration											
17	Administrative	22,782	-	105,002	127,784		127,784	(22,895)	104,889			17
18	Directors Fees			-	-		-	-	-			18
19	Professional Services			20,735	20,735		20,735	2,685	23,420			19
20	Dues, Fees, Subscriptions & Promotions			4,282	4,282		4,282	300	4,582			20
21	Clerical & General Office Expenses	91,099	-	56,109	147,208		147,208	(120,766)	26,442			21
22	Employee Benefits & Payroll Taxes			145,530	145,530		145,530	5,997	151,527			22
23	Inservice Training & Education			-	-		-	-	-			23
24	Travel and Seminar			-	-		-	-	-			24
25	Other Admin. Staff Transportation		-	5,085	5,085		5,085	388	5,473			25
26	Insurance-Prop.Liab.Malpractice			29,415	29,415		29,415	383	29,798			26
27	Other (specify):* Mgmt Alloc of Benefit	-	-	-	-		-	5,221	5,221			27
28	**TOTAL General Administration**	113,881	-	366,158	480,039	-	480,039	(128,687)	351,352			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,094,144	155,500	426,003	1,675,647	-	1,675,647	(134,112)	1,541,535			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 Crossing at Amboy #0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,156	8,156		8,156	55,597	63,753			30
31	Amortization of Pre-Op. & Org.			1,407	1,407		1,407	-	1,407			31
32	Interest			-	-		-	-	-			32
33	Real Estate Taxes			20,356	20,356		20,356	14,530	34,886			33
34	Rent-Facility & Grounds			105,000	105,000		105,000	(105,000)	-			34
35	Rent-Equipment & Vehicles			1,184	1,184		1,184	309	1,493			35
36	Other (specify):*			-	-		-	-	-			36
37	**TOTAL Ownership**			136,103	136,103	-	136,103	(34,564)	101,539			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	33,650	154,509	188,159		188,159	-	188,159			39
40	Barber and Beauty Shops	-	-	-	-		-	-	-			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			99,753	99,753		99,753	-	99,753			42
43	Other (specify):* Non-Allowable Cos	-	-	32,811	32,811		32,811	(32,811)	-			43
44	**TOTAL Special Cost Centers**	-	33,650	287,073	320,723	-	320,723	(32,811)	287,912			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,094,144	189,150	849,179	2,132,473	-	2,132,473	(201,487)	1,930,986			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 Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,995)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,566)	43		24
25	Fund Raising, Advertising and Promotional				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	(10,941)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,502)		$	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)	(175,985)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (175,985)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (201,487)		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 Crossing at Amboy

ID# 0054627

Report Period Beginning: 7/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (1,063)	43	1
2	X-rays - Part A	(934)	43	2
3	Managed Care Costs	(20,708)	43	3
4	Classified Advertising	(2,540)	43	4
5	To Reallocate Management Fees	15,978	17	5
6	State Replacement Tax	(1,674)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(10,941)		49

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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 PG 6 Supplemental		See PG 6 Supplemental		See PG 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. [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)	
1	V	19	Accounting	$	Green Acres Property LLC		$ 2,028	$ 2,028	1
2	V	21	Clerical & General Office	147,335	Green Acres Property LLC			(147,335)	2
3	V	30	Depreciation		Green Acres Property LLC		61,612	61,612	3
4	V	33	Real Estate Taxes		Green Acres Property LLC		33,880	33,880	4
5	V	34	Rent	125,356	Green Acres Property LLC			(125,356)	5
6	V	43	Replacement Tax				1,674	1,674	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 272,691			$ 99,194	$ * (173,497)	14

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

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	2	Food	$	SW Financial Services Company	100.00%	$ 9	$ 9	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	31	31	16
17	V	5	Utilities		SW Financial Services Company	100.00%	325	325	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	532	532	18
19	V	17	Administrative	45,002	SW Financial Services Company	100.00%	6,129	(38,873)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	332	332	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	300	300	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	26,569	26,569	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	90	90	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	298	298	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	383	383	25
26	V	27	Other		SW Financial Services Company	100.00%	5,221	5,221	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	980	980	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	1,006	1,006	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	309	309	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			$ 45,002			$ 42,514	$ * (2,488)	39

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

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	Moshe Herman	61.00%	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing	Shabbona	Supportive Living	1
2	Joshua Graber	15.00%	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Hillel Bachrach	15.00%			SW Financial	Skokie	Bookkeeping/	3
4	David Zuckerman	5.00%			Services Co.		Management Comp.	4
5	Robin Krystal	4.00%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6			Oregon Living & Rehabilitation, LLC	Oregon				6
7			Prairie Crossing Living & Rehab Center, LLC	Shabbona	Groves Community	Independence, MO	Hospice	7
8			Maple Crossing at Amboy	Amboy	Hospice			8
9			Tower Hill Rehabilitation, LLC	Soth Elgin, IL	Forest View Senior	Independence, MO	Independent	9
10					Residences		Living	10
11			Beauvais Manor Healthcare and Rehab	St. Louis, MO	White Oak Living	Independence, MO	Residential	11
12			Hillside Manor Healthcare and Rehab	St. Louis, MO	Center		Care	12
13			Rancho Manor Healthcare and Rehab	Florissant, MO				13
14			Rosewood Health & Rehab	Independence, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15			Seasons Care Center	Kansas City, MO	Program LLC			15
16			Carriage Square	St. Joseph, MO				16
17			Linn Living & Rehabilitation Center	Linn, MO	Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20					Property LLC			20
21								21
22					FOM Property LLC	Franklin Grove	Real Estate	22
23								23
24					Oregon Property LLC	Oregon	Real Estate	24
25					Shabbona Building	Shabbona	Real Estate	25
26					Associates LLC			26
27								27
28					Tower Hill Property L	South Elgin	Real Estate	28
29								29
30								30

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	15
16								16
17					Carriage Square Prop	St. Joseph, MO	Real Estate	17
18								18
19					Linn Property LLC	Linn, MO	Real Estate	19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	Moshe Herman	Owner	Administrative	61.00	See Sch 7A	6	13.33	Salary & Fees	77,711	17(3),(7)	1
2	David Zuckerman	Owner	Administrative	5.00	See Sch 7B	1	2.22	Salary	3,440	17(7)	2
3	Sheldon Wolfe	Administrative	Administrative	0.00	See Sch 7C	1	2.22	Salary	956	17(7)	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 82,107		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 Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 2/31/2017

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: SW Financial Services Company
Street Address: 7434 North Skokie Blvd
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	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	2	Food	Bed Days Available	736,091	14	$ 368	$	17,848	$ 9	1
2	3	Housekeeping	Bed Days Available	736,091	14	1,294		17,848	31	2
3	5	Utilities	Bed Days Available	736,091	14	13,401		17,848	325	3
4	6	Maintenance	Bed Days Available	736,091	14	21,957		17,848	532	4
5	19	Professional Services-Legal	Bed Days Available	736,091	14	314		17,848	8	5
6	19	Professional Services-Other	Bed Days Available	736,091	14	13,344		17,848	324	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	736,091	14	12,352		17,848	299	7
8	21	Clerical & General Office Expense	Bed Days Available	736,091	14	904,631	904,631	17,848	21,935	8
9	21	Clerical & General Office Expense	Bed Days Available	736,091	14	191,115		17,848	4,634	9
10	24	Travel & Seminar	Bed Days Available	736,091	14	3,725		17,848	90	10
11	25	Other Admin. Staff Transportion	Bed Days Available	736,091	14	12,311		17,848	299	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	736,091	14	15,785		17,848	383	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	736,091	14	215,324		17,848	5,221	13
14	33	Real Estate Taxes	Bed Days Available	736,091	14	41,499		17,848	1,006	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	736,091	14	12,753		17,848	309	15
16										16
17	17	Administrative	Avg. Hours Worked	45	14	43,000	43,000	1	956	17
18	17	Administrative	Avg. Hours Worked	45	14	154,818	154,818	1	3,440	18
19	17	Administrative	Avg. Hours Worked	45	4	13,000	13,000	6	1,733	19
20	30	Depreciation	Direct Cost	40,403	14				980	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,670,991	$ 1,115,449		$ 42,514	25

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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 Crossing at Amboy # 0054627 **Report Period Beginning:** 7/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 34,696	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.)	2016	$ 33,880	2
3. Under or (over) accrual (line 2 minus line 1).		$ (816)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,696	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
	Alloc Fr. Mgmt Co.	1,006	
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.		$ 34,886	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014		10
2015		11
2016	33,880	12

2016 taxes of $33,880 * 102.4% = $34,696

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Maple Crossing at Amboy COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0054627

CONTACT PERSON REGARDING THIS REPORT Moshe Herman

TELEPHONE (815) 857-2550 FAX #: (815) 857-4016

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-15-328-002	Long Term Care Property	$ 33,880.30	$ 33,880.30
2.	10-28-412-049-0000	SW Management Allocation	$ 39,551.00	$ 1,006.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,431.30	$ 34,886.30

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 12,060 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 1,407 4. Dates Incurred: 6/1/17-12/31/17

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	Resident Care		2013	$ 45,381	1
2					2
3	TOTALS			$ 45,381	3

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	97		2013		710,979	$ -	27.5	$ 25,854	$ 25,854	$ 117,420	4
5						-		-			5
6						-		-			6
7			Allocated from Management Compa		10,453	-	39.5	299	299	6,766	7
8						-		-			8
	Improvement Type**										
9	Hot Water Heater			2014	7,500		27.5	273	273	990	9
10	Improvements			2014	42,971		27.5	1,563	1,563	5,015	10
11											11
12	Replace 72' of soffit and facia - Exterior of building			2017	3,200	15	27.5	58	43	58	12
13	Electronic door locks - All locking non-resident rooms			2017	3,015	3,015	5	302	(2,713)	302	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	Allocated from Management Company				6,918			269	269	4,151	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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)		$ 785,036	$ 3,030		$ 28,618	$ 25,588	$ 134,702	70

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

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	$ 290,614	$	$ 30,617	$ 30,617	5	$ 267,065	71
72	Current Year Purchases	8,009	5,126	801	(4,325)	5	801	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.	4,313		156	156		3,101	74
75	TOTALS	$ 302,936	$ 5,126	$ 31,574	$ 26,448		$ 270,967	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	Patient Transport	Ford 350	2014	24,159		3,305	$ 3,305	5	$ 19,201	76
77										77
78										78
79	Allocation from Management	2017 Land Rover Enrique	2017	2,560	-	256	256	5	256	79
80	TOTALS			$ 26,719	$	$ 3,561	$ 3,561		$ 19,457	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)	$ 1,160,072	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,156	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,753	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 55,597	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 425,126	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 Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,184 Description: Nursing rental $1,184
(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	Allocated from Management Company		$	$ 309	17
18					18
19					19
20					20
21	TOTAL		$	$ 309	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 & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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 Crossing at Amboy STATE OF ILLINOIS # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	$	882	63,470	$	882	$ 63,470	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		477	22,903		477	22,903	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,065	68,136		1,065	68,136	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				32,261		32,261	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					1,389		1,389	12
13	Other (specify):									13
14	TOTAL			$	2,424	$ 154,509	$ 33,650	2,424	$ 188,159	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 & ID Number Maple Crossing at Amboy **#** 0054627 **Report Period Beginning:** 7/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	1,170,104	1,170,104	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,962	19,962	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		111,277	8
9	Other(specify): See Sch 17A	30,141	30,141	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,220,207	$ 1,331,484	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		45,381	13
14	Buildings, at Historical Cost		721,432	14
15	Leasehold Improvements, at Historical Cost	3,200	63,604	15
16	Equipment, at Historical Cost	11,024	329,655	16
17	Accumulated Depreciation (book methods)	(8,156)	(425,126)	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 Org Costs	10,653	10,653	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,721	$ 745,599	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,236,928	$ 2,077,083	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,902	$ 119,902	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,516	110,516	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,985	14,985	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,448	34,696	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	331,735	349,183	36
37	Due To/From Green Acres	90,000	90,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 684,586	$ 719,282	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	Prior Owner Balance	52,949	(54,499)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 52,949	$ (54,499)	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 737,535	$ 664,783	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 499,393	$ 1,412,300	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,236,928	$ 2,077,083	48

***(See instructions.)**

Facility Name: **Maple Crossing at Amboy**
IDPH License ID Number: **0054627**
Fiscal Year End: **12/31/2017**

Schedule 17A

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

	Description	Operating	After Consolidation
2073	NH DUE FROM STATE	-	-
3010	EMPLOYEE LOANS	485	485
3029	REIMBURSEMENT DUE	29,656	29,656
3030	SHORT TERM LOAN EXCHANGE	-	-
	Total - Line 9	**30,141**	**30,141**

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

	Description	Operating	After Consolidation
7165	DUE - PRO-RATION LIABILITY	-	-
7310	ACCRUED EXPENSES	246,735	264,183
7325	ACCRUED MANAGEMENT FEES	60,000	60,000
7610	SHORT TERM LOAN EXCHANGE	25,000	25,000
	Total - Line 36	**331,735**	**349,183**

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		249,393	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)**	$	249,393	17
	B. Transfers (Itemize):			
18	**Untaxable Taxable Income**		250,000	18
19				19
20				20
21				21
22				22
23	**TOTAL Transfers (sum of lines 18-22)**	$	250,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	499,393	24 *

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

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	$ 2,306,421	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,306,421	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	75,445	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 75,445	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,381,866	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	354,760	31
32	Health Care	840,848	32
33	General Administration	480,039	33
	B. Capital Expense		
34	Ownership	136,103	34
	C. Ancillary Expense		
35	Special Cost Centers	220,970	35
36	Provider Participation Fee	99,753	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,132,473	40
41	**Income before Income Taxes (line 30 minus line 40)****	249,393	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 249,393	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 794,748	44
45	Private Pay - Net Inpatient Revenue	649,823	45
46	Medicare - Net Inpatient Revenue	537,999	46
47	Other-(specify) **Insurance**	(17,462)	47
48	Other-(specify) **Pending**	341,313	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,306,421	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.**

^ Entity is a cash basis taxpayer.

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

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	999	1,040	$ 42,085	$ 40.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,651	3,782	127,959	33.83	3
4	Licensed Practical Nurses	6,289	6,685	207,040	30.97	4
5	CNAs & Orderlies	21,554	22,743	370,430	16.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,733	1,808	23,648	13.08	10
11	Social Service Workers	962	1,040	19,612	18.86	11
12	Dietician					12
13	Food Service Supervisor	944	1,040	17,151	16.49	13
14	Head Cook	2,338	2,444	33,207	13.59	14
15	Cook Helpers/Assistants	2,631	2,750	27,592	10.03	15
16	Dishwashers					16
17	Maintenance Workers	1,653	1,690	28,018	16.58	17
18	Housekeepers	5,449	5,688	62,863	11.05	18
19	Laundry	1,751	1,849	20,658	11.17	19
20	Administrator	400	400	22,782	56.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,575	3,666	91,099	24.85	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 Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	53,929	56,625	$ 1,094,144 *	$ 19.32	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	$ 379	1(3)	35
36	Medical Director	Monthly	1,495	9(3)	36
37	Medical Records Consultant	Monthly	8,532	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,088	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,494		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 Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carolyn Progress	Administrator	0	$ 22,782
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 22,782

B. Administrative - Other

Description	Amount
SW Financial Services (Elim on Sch V, Col 7)	$ 45,002
Moshe Herman/Momentum Healthcare, LLC	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 105,002
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planner, Inc.	Unemployment Consultant	$ 390
Melanie's Consulting Services	Consultant	520
Meyer Magence	Legal	825
RSM US LLP	Accounting	19,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 20,735

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,250
Unemployment Compensation Insurance	18,385
FICA Taxes	85,678
Employee Health Insurance	12,796
Employee Meals	5,997
Illinois Municipal Retirement Fund (IMRF)*	
Employe Physicals	
Life Insurance	(527)
Employe Benefits - Other	(52)
TOTAL (agree to Schedule V, line 22, col.8)	$ 151,527

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	561
Licenses and Permits	1,825
Allocated from Home Office	300
Ability	1,896
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,582

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
N/A	
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Maple Crossing at Amboy**
IDPH License ID Number: **0054627**
Fiscal Year End: **12/31/2017**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
See Pg 21 Schedule C		20,735
Total (agree to Schedule V, line 19, column 3)		20,735
Allocated from Home Office	Professional Services	649
Allocated from Real Estate Entity	Professional Services	2,028
Allocated from Home Office	Legal Expenses	8
Less: Non-Allowable Legal Fees		
Total (agree to Schedule V, line 19, column 8)		23,420

Facility Name & ID Number Maple Crossing at Amboy # 0054627 Report Period Beginning: 7/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,078** Line **10**

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

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

(9) Are you presently operating under a sublease agreement? 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. $ **99,753**
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. $ **5,997** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **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? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) 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