

		FOR OHF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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.

<p>I. IDPH Facility ID Number: <u>0044172</u></p> <p>Facility Name: <u>MAPLE CREST CARE CENTRE</u></p> <p>Address: <u>4452 SQUAW PRAIRIE ROAD</u> <u>BELVIDERE</u> <u>61008</u> <small>Number City Zip Code</small></p> <p>County: <u>BOONE</u></p> <p>Telephone Number: <u>(815) 547-6377</u> Fax # <u>(815) 547-3857</u></p> <p>IDPA ID Number: <u>36-4253834</u></p> <p>Date of Initial License for Current Owners: <u>02/01/99</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>SHAEL BELLOWS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MANAGEMENT CONSULTANT</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>SHAEL BELLOWS</u>			(Title) <u>MANAGEMENT CONSULTANT</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____		(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>			(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>			(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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 12/11/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>78</u>	Skilled (SNF)	<u>84</u>	<u>28,596</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>78</u>	TOTALS	<u>84</u>	<u>28,596</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,342</u>	<u>1,575</u>	<u>3,392</u>	<u>7,309</u>	8
9	SNF/PED					9
10	ICF	<u>11,133</u>	<u>7,533</u>	<u>1,416</u>	<u>20,082</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,475</u>	<u>9,108</u>	<u>4,808</u>	<u>27,391</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.79%

D. How many bed-hold days during this year were paid by Public Aid? 154 (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)

COUNTY JAIL MEALS

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

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

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

I. On what date did you start providing long term care at this location?
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/99 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 84 and days of care provided 2,831

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number

MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	180,160	7,210	8,147	195,517		195,517	(6)	195,511		1
2	Food Purchase		184,413		184,413		184,413	(138,693)	45,720		2
3	Housekeeping	51,063	15,885	0	66,948		66,948	(438)	66,510		3
4	Laundry	29,771	11,012	2,438	43,221		43,221	193	43,414		4
5	Heat and Other Utilities			86,711	86,711		86,711	0	86,711		5
6	Maintenance	53,064	28,568	44,377	126,009		126,009	(1,292)	124,717		6
7	Other (specify):*			2,836	2,836		2,836	0	2,836		7
8	TOTAL General Services	314,058	247,088	144,509	705,655	0	705,655	(140,236)	565,419		8
	B. Health Care and Programs										
9	Medical Director	0		3,600	3,600		3,600	0	3,600		9
10	Nursing and Medical Records	1,013,713	64,561	294,050	1,372,324		1,372,324	352	1,372,676		10
10a	Therapy	74,101		12,082	86,183		86,183	0	86,183		10a
11	Activities	62,574	1,835	2,658	67,067		67,067	(310)	66,757		11
12	Social Services	26,085		10,936	37,021		37,021	0	37,021		12
13	Nurse Aide Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,176,473	66,396	323,326	1,566,195	0	1,566,195	42	1,566,237		16
	C. General Administration										
17	Administrative	62,678		270,148	332,826		332,826	(266,714)	66,112		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			103,626	103,626		103,626	1,522	105,148		19
20	Dues, Fees, Subscriptions & Promotions			33,325	33,325		33,325	(22,086)	11,239		20
21	Clerical & General Office Expenses	57,470	28,799	16,303	102,572		102,572	66,102	168,674		21
22	Employee Benefits & Payroll Taxes			266,905	266,905		266,905	0	266,905		22
23	Inservice Training & Education			4,136	4,136		4,136	0	4,136		23
24	Travel and Seminar			0	0		0	5,270	5,270		24
25	Other Admin. Staff Transportation			2,616	2,616		2,616	0	2,616		25
26	Insurance-Prop.Liab.Malpractice			65,136	65,136		65,136	1,692	66,828		26
27	Other (specify):*			23,363	23,363		23,363	(23,363)	0		27
28	TOTAL General Administration	120,148	28,799	785,558	934,505	0	934,505	(237,577)	696,928		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,610,679	342,283	1,253,393	3,206,355	0	3,206,355	(377,771)	2,828,584		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

#0044172

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			41,456	41,456		41,456	(19,345)	22,111		30
31	Amortization of Pre-Op. & Org.			10,000	10,000		10,000	0	10,000		31
32	Interest			83,474	83,474		83,474	(2,772)	80,702		32
33	Real Estate Taxes			54,310	54,310		54,310	0	54,310		33
34	Rent-Facility & Grounds			48,333	48,333		48,333	3,787	52,120		34
35	Rent-Equipment & Vehicles			8,025	8,025		8,025	3,409	11,434		35
36	Other (specify):*				0		0	0	0		36
37	TOTAL Ownership			245,598	245,598	0	245,598	(14,921)	230,677		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		63,528	101,259	164,787		164,787	0	164,787		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			42,894	42,894		42,894	0	42,894		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	63,528	144,153	207,681	0	207,681	0	207,681		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,610,679	405,811	1,643,144	3,659,634	0	3,659,634	(392,692)	3,266,942		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(137,334)	2		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	(22,053)	30		9
10	Interest and Other Investment Income	(2,772)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,359)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(35)	21		18
19	Entertainment	(17,019)	20		19
20	Contributions	(344)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(924)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,363)	27		24
25	Fund Raising, Advertising and Promotional	(4,987)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(689)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(11,530)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (222,409)		\$ 0	30

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	2	
		Amount	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)	(170,283)	PG 6	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (170,283)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (392,692)		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.

		1	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

MAPLE CREST CARE CENTRE

ID# 0044172

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ -1314	6	1
2	VACATION ACCRUAL	(6)	1	2
3	VACATION ACCRUAL	(438)	3	3
4	VACATION ACCRUAL	193	4	4
5	VACATION ACCRUAL	22	6	5
6	VACATION ACCRUAL	(4,689)	10	6
7	VACATION ACCRUAL	(310)	11	7
8	VACATION ACCRUAL	(4,250)	17	8
9	VACATION ACCRUAL	(738)	21	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
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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	(11,530)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2001

Ending:

12/31/2001**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(6)	0	0	0	0	0	0	0	0	0	0	(6)	1
2	Food Purchase	(138,693)	0	0	0	0	0	0	0	0	0	0	(138,693)	2
3	Housekeeping	(438)	0	0	0	0	0	0	0	0	0	0	(438)	3
4	Laundry	193	0	0	0	0	0	0	0	0	0	0	193	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,292)	0	0	0	0	0	0	0	0	0	0	(1,292)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(140,236)	0	0	0	0	0	0	0	0	0	0	(140,236)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,689)	5,041	0	0	0	0	0	0	0	0	0	352	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(310)	0	0	0	0	0	0	0	0	0	0	(310)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,999)	5,041	0	42	16								
	C. General Administration													
17	Administrative	(4,250)	(262,464)	0	0	0	0	0	0	0	0	0	(266,714)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(924)	2,446	0	0	0	0	0	0	0	0	0	1,522	19
20	Fees, Subscriptions & Promotions	(23,039)	953	0	0	0	0	0	0	0	0	0	(22,086)	20
21	Clerical & General Office Expenses	(773)	66,875	0	0	0	0	0	0	0	0	0	66,102	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,270	0	0	0	0	0	0	0	0	0	5,270	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,692	0	0	0	0	0	0	0	0	0	1,692	26
27	Other (specify):*	(23,363)	0	0	0	0	0	0	0	0	0	0	(23,363)	27
28	TOTAL General Administration	(52,349)	(185,228)	0	(237,577)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(197,584)	(180,187)	0	(377,771)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2001 Ending:12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(22,053)	2,708	0	0	0	0	0	0	0	0	0	(19,345)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,772)	0	0	0	0	0	0	0	0	0	0	(2,772)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	3,787	0	0	0	0	0	0	0	0	0	3,787	34
35	Rent-Equipment & Vehicles	0	3,409	0	0	0	0	0	0	0	0	0	3,409	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(24,825)	9,904	0	(14,921)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(222,409)	(170,283)	0	(392,692)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		FIRST HEALTH CARE ASSOCIATES,, LTD. (DIVISION OF FHC ENTERPRISE, INC.)	ROSEMONT	MANAGEMENT/ CONSULTANT

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 NURSING	\$	FHC ENTERPRISES INC.		\$ 5,041	\$ 5,041	1
2	V	17 ADMINISTRATIVE	270,148	MR. BELLOWS OWNS 67.50% OF THIS FACILITY		7,684	(262,464)	2
3	V	19 PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		2,446	2,446	3
4	V	20 DUES & SUBSCRIPTIONS		" "		953	953	4
5	V	21 CLERICAL		" "		66,875	66,875	5
6	V	24 TRAVEL		" "		5,270	5,270	6
7	V	26 INSURANCE		" "		1,692	1,692	7
8	V	30 DEPRECIATION		" "		2,708	2,708	8
9	V	34 RENT		" "		3,787	3,787	9
10	V	35 RENT-EQUIPMENT & VEH.		" "		3,409	3,409	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 270,148			\$ 99,865	\$ * (170,283)	14

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

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								\$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	67.50	SEE ATTACHED	1.04	5.49	SALARY	7,684	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,684		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

0044172 Report Period Beginning: 01/01/2001

Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization FHC ENTERPRISES INC.
 Street Address 10700 W. HIGGINS ROAD, STE. 300
 City / State / Zip Code ROSEMONT, IL 60018
 Phone Number (847) 296-9625
 Fax Number (847) 298-0824

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	501,904	10	\$ 92,369	\$ 27,391	\$ 5,041	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	27,391	7,684	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800	27,391	2,446	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462	27,391	953	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,659	27,391	7,134	5
6	21	CLERICAL	DIRECT COST	1	1	59,741	59,741	1	59,741
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528	27,391	5,270	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995	27,391	1,692	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603	27,391	2,708	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364	27,391	3,787	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	501,904	10	62,438	27,391	3,409	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 794,776	\$ 292,927	\$ 99,865	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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	11											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
A. Directly Facility Related																					
Long-Term																					
1																					
2																					
3																					
4																					
5																					
Working Capital																					
6	MEMBER LOANS		X	WORKING CAPITAL	DEMAND	VARIES	150,000	186,523	DEMAND	0.0775	13,416										
7	RELATED PARTY		X	WORKING CAPITAL	DEMAND	VARIES	721,000	860,483	DEMAND	SEE SCH	70,058										
8																					
9	TOTAL Facility Related						\$ 871,000	\$ 1,047,006			\$ 83,474										
B. Non-Facility Related*																					
10																					
11																					
12																					
13																					
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0										
15	TOTALS (line 9+line14)						\$ 871,000	\$ 1,047,006			\$ 83,474										

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

(See instructions.)

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

(See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2000 report.		\$ 42,696	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.)		\$ 48,238	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 5,542	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 48,768	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 19 _____ 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.		\$ 54,310	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 _____	8	
	1997 _____	9	
	1998 _____	10	
	1999 42,234	11	
	2000 48,238	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL		FOR OHF USE ONLY	
		13 FROM R. E. TAX STATEMENT FOR 2000 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.			

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.

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAPLE CREST CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044172

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-14-100-015</u>	<u>NURSING HOME</u>	\$ <u>48,238.00</u>	\$ <u>48,238.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>48,238.00</u>	\$ <u>48,238.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2001 Ending:

12/31/2001

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. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: 50,000 2. Number of Years Over Which it is Being Amortized: 60 MONTHS

3. Current Period Amortization: 10,000 4. Dates Incurred: 1999

Nature of Costs: LEGAL COSTS

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>653,400</u>		\$	1
2					2
3	TOTALS	653,400		\$ 0	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		WALLCOVERING/BORDERS/VINYL COVERINGS	1999		17,944	2,563	7	2,563		6,931	9
10		STEEL FLOORS	1999		2,337	85	27.5	85		225	10
11		SIGN, SIGN FOOTINGS AND BRICKS	1999		4,652	169	27.5	169		359	11
12		REMODEL-DINING & REC RM. OFFICES, HALLS	1999		73,951	2,689	27.5	2,689		5,939	12
13		CONDENSING UNIT FOR WALK IN FREEZER	2000		3,695	134	27.5	134		151	13
14		WATER SOFTENER UNIT	2000		10,120	368	27.5	368		414	14
15		ARCHITECTURAL DRAWINGS FOR ADDING 6 BEDS	2001		11,239	392	27.5	392		392	15
16		TWO HOT WATER HEATERS	2001		13,065	455	27.5	455		455	16
17		REMOVAL OF WATER TANKS & PIPING	2001		7,650	243	27.5	243		243	17
18		REPAIRS TO GRAVEL ROOF	2001		2,875	65	27.5	65		65	18
19		BLACKTOP PARKING LOT	2001		1,270	29	27.5	29		29	19
20		AIRCONDITIONING - REPAIRS & INSTALLATION - DINING ROOM	2001		7,430	146	27.5	146		146	20
21		ASBESTOS ABATEMENT/FLOOR RENOVATION	2001		1,400	26	27.5	26		26	21
22		REPLACE WATER COIL - FOOD STORAGE AREA	2001		7,500	102	27.5	102		102	22
23		INSTALL CONTROL DAMPER IN BATHING AREA	2001		1,795	14	27.5	14		14	23
24		BOILER ROOM EXHAUST FAN	2001		1,980	15	27.5	15		15	24
25		REPLACE DAMPER ON GENERATOR	2001		1,260	6	27.5	6		6	25
26		ADDITION OF 6 BEDS-GENERAL CONSTR/WINDOWS/PAINTING	2001		103,815	472	27.5	472		472	26
27		EXHAUST FANS FOR KITCHEN & DISHWASHING AREA	2001		5,894	27	27.5	27		27	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	279,872	\$	8,000	\$	8,000	\$	0	\$	16,011	70

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

Facility Name & ID Number **MAPLE CREST CARE CENTRE**

0044172

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 101,238	\$ 22,472	\$ 9,041	\$ (13,431)	3-15YRS	\$ 22,504	71
72	Current Year Purchases	54,920	10,984	2,362	(8,622)	3-15 YRS	2,362	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	41,162	2,708	2,708	0		38,513	74
75	TOTALS	\$ 197,320	\$ 36,164	\$ 14,111	\$ (22,053)		\$ 63,379	75

D. Vehicle Depreciation (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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	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)	\$ 477,192	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,164	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,111	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,053)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 79,390	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: COUNTY OF BOONE

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		78	02/01/99	\$ 48,333			3
4	Additions	12/11/2001	6					4
5								5
6								6
7	TOTAL		84		\$ 48,333			7

10. Effective dates of current rental agreement:
Beginning 02/01/99
Ending 02/01/30

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2002</u>	\$ <u>59,167</u>
13.	<u>12/31/2003</u>	\$ <u>87,500</u>
14.	<u>12/31/2004</u>	\$ <u>91,650</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,025 Description: SEE SCHEDULE ATTACHED

(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			\$ 0.00	\$ 0	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility				Total
	1 Drop-outs	2 Completed	3 Contract	4	
1 Community College Tuition	\$	\$	\$	\$	0
2 Books and Supplies					0
3 Classroom Wages (a)					0
4 Clinical Wages (b)					0
5 In-House Trainer Wages (c)					0
6 Transportation					0
7 Contractual Payments					0
8 Nurse Aide Competency Tests					0
9 TOTALS	\$ 0	\$ 0	\$ 0	\$	0
10 SUM OF line 9, col. 1 and 2 (e)	\$ 0				

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	\$		\$ 42,305	\$		\$ 42,305	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,769			4,769	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			53,635			53,635	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			550			550	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				50,347		50,347	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, XRAY, RENTALS, I.V. THERAPY Other (specify):	39-2					13,181		13,181	13
14	TOTAL			\$		\$ 101,259	\$ 63,528		\$ 164,787	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 nurse aides, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 14,890	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	543,034		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,938		6
7	Other Prepaid Expenses	1,125		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 579,987	\$ 0	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	279,872		15
16	Equipment, at Historical Cost	156,157		16
17	Accumulated Depreciation (book methods)	(82,376)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	50,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,167)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 374,486	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 954,473	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 183,848	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,925		28
29	Short-Term Notes Payable	860,483		29
30	Accrued Salaries Payable	58,593		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,460		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,768		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	MANAGEMENT FEES	271,750		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,463,827	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	186,523		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)	\$ 186,523	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,650,350	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (695,877)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 954,473	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (575,169)	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (575,168)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(120,709)	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)	\$ (120,709)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (695,877)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,394,007	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,394,007	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	100	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)	\$ 100	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income****	2,772	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,772	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	4,712	28
28a	COUNTY JAIL MEAL REIMBURSEMENT	137,334	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 142,046	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,538,925	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	705,655	31
32	Health Care	1,566,195	32
33	General Administration	934,505	33
	B. Capital Expense		
34	Ownership	245,598	34
	C. Ancillary Expense		
35	Special Cost Centers	164,787	35
36	Provider Participation Fee	42,894	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,659,634	40
41	Income before Income Taxes (line 30 minus line 40)**	(120,709)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (120,709)	43

* 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.
TAX RETURN PREPARED ON CASH BASIS

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	758	817	\$ 27,575	\$ 33.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,608	7,042	144,940	20.58	3
4	Licensed Practical Nurses	14,615	15,801	272,887	17.27	4
5	Nurse Aides & Orderlies	40,038	43,291	451,794	10.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,104	4,601	74,101	16.11	8
9	Activity Director	1,893	2,110	27,329	12.95	9
10	Activity Assistants	3,800	4,205	35,245	8.38	10
11	Social Service Workers	1,910	2,133	26,085	12.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,977	5,479	74,485	13.59	14
15	Cook Helpers/Assistants	13,485	14,449	105,675	7.31	15
16	Dishwashers					16
17	Maintenance Workers	3,930	4,190	53,064	12.66	17
18	Housekeepers	7,336	7,822	51,063	6.53	18
19	Laundry	4,289	4,557	29,771	6.53	19
20	Administrator	1,977	2,054	62,678	30.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,320	3,754	57,470	15.31	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	6,057	6,423	116,517	18.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	119,097	128,728	\$ 1,610,679 *	\$ 12.51	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	176	\$ 7,944	1-3	35
36	Medical Director	42	3,600	9-3	36
37	Medical Records Consultant	24	1,080	10-3	37
38	Nurse Consultant	2,398	83,020	10-3	38
39	Pharmacist Consultant	300	936	10-3	39
40	Physical Therapy Consultant	168	5,915	10a-3	40
41	Occupational Therapy Consultant	168	6,167	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	53	2,658	11-3	44
45	Social Service Consultant	180	10,936	12-3	45
46	Other(specify) <u>PSYCHO SOCIAL</u>	60	4,668	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,569	\$ 126,924		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	483	\$ 14,776	10-3	50
51	Licensed Practical Nurses	1,433	40,735	10-3	51
52	Nurse Aides	7,986	148,835	10-3	52
53	TOTAL (lines 50 - 52)	9,902	\$ 204,346		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
MARIE HARTZOG	ADMIN		\$ 62,678	Workers' Compensation Insurance		\$ 29,354	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance		28,885	Advertising: Employee Recruitment	6,174	
				FICA Taxes		121,117	Health Care Worker Background Check	338	
				Employee Health Insurance		74,428	(Indicate # of checks performed _____)		
				Employee Meals		0	MARKETING/ADV/PROMO	22,695	
				Illinois Municipal Retirement Fund (IMRF)*			RELATED PARTY	953	
				EMPLOYEE BENEFITS - OTHER		8,011	CONTRIBUTIONS	344	
				EMPLOYEE PHYSICAL EXAMS		780	DUES & SUBSCRIPTIONS	1,954	
				PENSION/PROFIT SHARING PLANS		4,330	LICENSES & PERMITS	1,820	
				CHICAGO HEAD TAX		0	TRUST FEES/FRANCHISE TX/ETC	(344)	
				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(17,019)	
				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(4,987)	
							Yellow page advertising	(689)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 62,678				\$ 266,905			\$ 11,239		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description			Description		
Amount				Line #			Amount		
FIRST HEALTH CARE - MANAGEMENT FEES							Out-of-State Travel		
\$ 270,148							\$		
							In-State Travel		
							0		
							RELATED PARTY		
							5,270		
							Seminar Expense		
							0		
							Entertainment Expense		
							()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
\$ 270,148				\$			\$ 5,270		
C. Professional Services									
Vendor/Payee				Description					
Type				Line #					
Amount				Amount					
\$				\$			\$		
SEE SCHEDULE ATTACHED									
103,626									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)									
\$ 103,626									

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2001	\$ 1,577		\$	\$	\$	\$ 263	\$ 525	\$ 525	\$ 264	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,577		\$	\$	\$	\$ 263	\$ 525	\$ 525	\$ 264	\$	\$

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

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? NO
If YES, give association name and amount. _____
- (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? _____
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 971 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 42,894
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 of Public Aid, 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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? NO
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,944
	REPAIRS & MAINTENANCE	203
		0
		8,147
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,438
		0
		2,438
5	HEAT & OTHER UTILITIES	
	GAS HEAT	38,152
	ELECTRICITY	40,022
	WATER	6,644
	CABLE TV - LOBBY	1,893
		0
		86,711
6	MAINTENANCE	
	GROUNDS MAINTENANCE	14,400
	PAINTING & DECORATING	1,577
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	25,900
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,662
	FIRE SERVICE	838
		0
		0
		0
		44,377
7	OTHER	
	SCAVENGER	2,656
	SECURITY SERVICE	180
		2,836
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,600
		3,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	204,346
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	4,668
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,080
	PHARMACY CONSULTANT XVIII B 39-2	936
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	83,020
		0
		0
		294,050
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,915
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	6,167
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		12,082
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,658
		0
		2,658
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	10,936
		0
		10,936
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	270,148
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,053
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	91,573
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	103,626
	ENTERTAINMENT & MARKETING VI 19 XIX F	17,019
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,987
	EMPLOYEE WANT ADS XIX F	6,174
	CONTRIBUTIONS VI 20 XIX F	344
	DUES & SUBSCRIPTIONS XIX F	1,954
	LICENSES & PERMITS XIX F	1,820
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	689
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	338
21	CLERICAL & GENERAL OFFICE EXPENSES	33,325
	BANK CHARGES	1,110
	EQUIPMENT REPAIR & MAINTENANCE	708
	OUTSIDE CLERICAL SERVICES	1,381
	PENALTIES / OVERDRAFT CHARGES VI 18	35
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	113
	TELEPHONE	12,910
	MESSENGER SERVICE	46
		0
		16,303

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	121,117
	UNEMPLOYMENT COMPENSATION XIX D	28,885
	WORKERS COMPENSATION INSURANC XIX D	29,354
	HOSPITALIZATION INSURANCE XIX D	74,428
	EMPLOYEE BENEFITS - OTHER XIX D	8,011
	EMPLOYEE PHYSICAL EXAMS XIX D	780
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	4,330
	CHICAGO HEAD TAX XIX D	0
		266,905
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,136
		4,136
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,616
		2,616
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	65,136
		65,136
27	OTHER	
	BAD DEBTS VI 24	23,363
		0
		23,363

GRAND TOTAL COLUMN 3 OTHER

1,253,393

MAPLE CREST CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	184,413	PATIENT MEALS	82173
LESS SALES TAX	(1,359)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	185772	TOTAL MEALS/YEAR	82173
TOTAL PATIENT CENSUS	27,391	NET FOOD	185772
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	82173

TOTAL PATIENT MEALS	82173	COST PER MEAL	2.26
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

MAPLE CREST CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									3,212,614	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,566,195	266,905	282,504	43,221	379,930	667,600	42,894	245,598		1,610,679
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	1,533		1,930			4,562		(8,025)		
CABLE TV			(1,893)			1,893				
CONTRACT NURSING										204,346
INTEREST INCOME							(2,772)			
NET VENDING COMMISSIONS							(4,712)			
EMPLOYEE PHYSICAL EXAMS		(780)				780				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(270,148)		270,148		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(23,363)	23,363			
DISCOUNTS LOST/JAIL MEAL REIMB.							(137,334)			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSIFIED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES/INCOME ADJ.	0	0	0	0	0	0	(17,256)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE/DENTAL	550	0	0	0	0	0	0	0		
TOTAL COSTS	1,568,278	266,125	282,541	43,221	379,930	381,324	(95,817)	507,721	3,333,323	1,815,025
PER FINANCIAL STATEMENTS	1,568,278	266,125	282,541	43,221	379,930	381,324	(95,817)	507,721	(120,709)	1,815,025
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									(120,709)	

MAPLE CREST CARE CENTRE - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		28,596			28548			48	26052		
CENSUS DAYS		27,391			26846			545	25286		
OCCUPANCY %		95.79%			94.04%				97.06%		
SALARIES											
TOTAL General Services	8-1	314,058	9.61%	11.47	316512	10.98%	11.79	(2,454)	288105	11.85%	11.39
Social Services	12-1	26,085	0.80%	0.95	24354	0.84%	0.91	1,731	20275	0.83%	0.80
TOTAL Health Care and Programs	16-1	1,176,473	36.01%	42.95	1079083	37.42%	40.20	97,390	852013	35.06%	33.70
Clerical & General Office Expenses	21-1	57,470	1.76%	2.10	57320	1.99%	2.14	150	48772	2.01%	1.93
TOTAL General Administration	28-1	120,148	3.68%	4.39	115120	3.99%	4.29	5,028	99415	4.09%	3.93
TOTAL Operation Expense	29-1	1,610,679	49.30%	58.80	1510715	52.39%	56.27	99,964	1239533	51.00%	49.02
ADJUSTED TOTALS											
Food	2-8	45,720	1.40%	1.67	14899	0.52%	0.55	30,821	42957	1.77%	1.70
Heat and Other Utilities	5-8	86,711	2.65%	3.17	84463	2.93%	3.15	2,248	64854	2.67%	2.56
Maintenance	6-8	124,717	3.82%	4.55	123695	4.29%	4.61	1,022	82782	3.41%	3.27
TOTAL General Services	8-8	565,419	17.31%	20.64	546090	18.94%	20.34	19,329	486178	20.00%	19.23
Administrative	17-8	66,112	2.02%	2.41	62325	2.16%	2.32	3,787	58054	2.39%	2.30
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0			
Professional Services	19-8	105,148	3.22%	3.84	162914	5.65%	6.07	(57,766)	95696	3.94%	3.78
Fees, Subscriptions, Promotions	20-8	11,239	0.34%	0.41	11374	0.39%	0.42	(135)	29712	1.22%	1.18
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	200	0.01%	0.01
License Fee-Other	Pg21	1,820	0.06%	0.07	752	0.03%	0.03	1,068	1899	0.08%	0.08
Clerical & General Office Expenses	21-8	168,674	5.16%	6.16	166374	5.77%	6.20	2,300	158906	6.54%	6.28
Employee Benefits & Payroll Taxes	22-8	266,905	8.17%	9.74	240845	8.35%	8.97	26,060	228580	9.41%	9.04
Payroll Taxes	Pg21	150,002	4.59%	5.48	143775	4.99%	5.36	6,227	122424	5.04%	4.84
W/C Insurance	Pg21	29,354	0.90%	1.07	27108	0.94%	1.01	2,246	17891	0.74%	0.71
Health Insurance	Pg21	74,428	2.28%	2.72	56333	1.95%	2.10	18,095	79701	3.28%	3.15
Inservice Training & Education	23-8	4,136	0.13%	0.15	6819	0.24%	0.25	(2,683)	4136	0.17%	0.16
Travel and Seminar	24-8	5,270	0.16%	0.19	5019	0.17%	0.19	251	3991	0.16%	0.16
Other Admin. Staff Transportation	25-8	2,616	0.08%	0.10	2950	0.10%	0.11	(334)	1910	0.08%	0.08
Insurance-Prop.Liab.Malpractice	26-8	66,828	2.05%	2.44	43983	1.53%	1.64	22,845	36703	1.51%	1.45
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	696,928	21.33%	25.44	702603	24.36%	26.17	(5,675)	617688	25.42%	24.43
TOTAL Operation Expense	29-8	2,828,584	86.58%	103.27	2591149	89.85%	96.52	237,435	2277352	93.71%	90.06
Real Estate Taxes	33-3	54,310	1.66%	1.98	29930	1.04%	1.11	24,380	55000	2.26%	2.18
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	3,266,942	100.00%	119.27	2883770	100.00%	107.42	383,172	2430334	100.00%	96.11
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1067394.1	32.67%	38.97	1076661	37.34%	40.11	(9,267)	946747.9	38.96%	37.44

MAPLE CREST CARE CENTRE - DIAGNOSTICS - 12/31/2001

This report DOES NOT REFLECT a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 263 from Page 22 and -1577 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest expense on Page 4 Line 32-4 = Page 9 Line 15-10.

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.

Deprn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-2708

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.

#VALUE!

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.