

		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>0042366</u></p> <p>Facility Name: <u>MAPLE RIDGE CARE CENTRE</u></p> <p>Address: <u>2202 N. KICKAPOO</u> <u>LINCOLN</u> <u>62656</u> <small>Number City Zip Code</small></p> <p>County: <u>LOGAN</u></p> <p>Telephone Number: <u>(217) 735-1538</u> Fax # <u>(217) 735-4818</u></p> <p>IDPA ID Number: <u>36-4109662</u></p> <p>Date of Initial License for Current Owners: <u>11/01/96</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 RIDGE CARE CENTRE

0042366 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 _____

	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	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	3,250	982	5,034	9,266	8
9	SNF/PED					9
10	ICF	22,824	6,880	2,766	32,470	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,074	7,862	7,800	41,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.29%

D. How many bed-hold days during this year were paid by Public Aid? 376 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 211 and days of care provided 2,804

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 RIDGE CARE CENTRE # 0042366 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	145,658	21,853	10,127	177,638		177,638	2,963	180,601		1
2	Food Purchase		160,320		160,320		160,320	(727)	159,593		2
3	Housekeeping	136,882	17,947	0	154,829		154,829	1,064	155,893		3
4	Laundry	22,672	10,581	0	33,253		33,253	495	33,748		4
5	Heat and Other Utilities			113,550	113,550		113,550	0	113,550		5
6	Maintenance	38,646	19,415	25,115	83,176		83,176	2,040	85,216		6
7	Other (specify):*			8,762	8,762		8,762	0	8,762		7
8	TOTAL General Services	343,858	230,116	157,554	731,528	0	731,528	5,835	737,363		8
	B. Health Care and Programs										
9	Medical Director	0		18,000	18,000		18,000	0	18,000		9
10	Nursing and Medical Records	1,211,010	58,998	8,215	1,278,223		1,278,223	17,194	1,295,417		10
10a	Therapy	0		5,688	5,688		5,688	0	5,688		10a
11	Activities	97,677	7,840	2,150	107,667		107,667	1,274	108,941		11
12	Social Services	4,149		2,150	6,299		6,299	0	6,299		12
13	Nurse Aide Training			982	982		982	0	982		13
14	Program Transportation			1,429	1,429		1,429	0	1,429		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,312,836	66,838	38,614	1,418,288	0	1,418,288	18,468	1,436,756		16
	C. General Administration										
17	Administrative	55,752		365,521	421,273		421,273	(353,811)	67,462		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			159,036	159,036		159,036	2,681	161,717		19
20	Dues, Fees, Subscriptions & Promotions			91,283	91,283		91,283	(73,297)	17,986		20
21	Clerical & General Office Expenses	115,331	21,174	84,375	220,880		220,880	93,193	314,073		21
22	Employee Benefits & Payroll Taxes			370,807	370,807		370,807	0	370,807		22
23	Inservice Training & Education			5,744	5,744		5,744	0	5,744		23
24	Travel and Seminar			893	893		893	8,031	8,924		24
25	Other Admin. Staff Transportation			8,065	8,065		8,065	0	8,065		25
26	Insurance-Prop.Liab.Malpractice			80,214	80,214		80,214	2,579	82,793		26
27	Other (specify):*			246,123	246,123		246,123	(246,123)	0		27
28	TOTAL General Administration	171,083	21,174	1,412,061	1,604,318	0	1,604,318	(566,747)	1,037,571		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,827,777	318,128	1,608,229	3,754,134	0	3,754,134	(542,444)	3,211,690		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 RIDGE CARE CENTRE

#0042366

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			36,426	36,426		36,426	110,275	146,701			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			161,898	161,898		161,898	140,807	302,705			32
33	Real Estate Taxes			28,839	28,839		28,839	0	28,839			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(306,229)	5,771			34
35	Rent-Equipment & Vehicles			19,071	19,071		19,071	5,195	24,266			35
36	Other (specify):* STORAGE			1,396	1,396		1,396	0	1,396			36
37	TOTAL Ownership			559,630	559,630	0	559,630	(49,952)	509,678			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		106,091	156,295	262,386		262,386	0	262,386			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			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	106,091	221,995	328,086	0	328,086	0	328,086			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,827,777	424,219	2,389,854	4,641,850	0	4,641,850	(592,396)	4,049,454			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				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	(16,648)	30		9
10	Interest and Other Investment Income	(51,061)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(727)	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	(229)	21		18
19	Entertainment	(22,846)	20		19
20	Contributions	(2,215)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,421)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(246,123)	27		24
25	Fund Raising, Advertising and Promotional	(43,747)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,942)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	23,661			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (367,298)		\$ 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)	(225,098)	PG 6&6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (225,098)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (592,396)		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	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 RIDGE CARE CENTRE

ID# 0042366

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2318	6	1
2	VACATION ACCRUAL	2,963	1	2
3	VACATION ACCRUAL	1,064	3	3
4	VACATION ACCRUAL	495	4	4
5	VACATION ACCRUAL	(278)	6	5
6	VACATION ACCRUAL	9,513	10	6
7	VACATION ACCRUAL	1,274	11	7
8	VACATION ACCRUAL	6,312	21	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
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35				35
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	23,661		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	2,963	0	0	0	0	0	0	0	0	0	0	2,963	1
2	Food Purchase	(727)	0	0	0	0	0	0	0	0	0	0	(727)	2
3	Housekeeping	1,064	0	0	0	0	0	0	0	0	0	0	1,064	3
4	Laundry	495	0	0	0	0	0	0	0	0	0	0	495	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,040	0	0	0	0	0	0	0	0	0	0	2,040	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	5,835	0	0	0	0	0	0	0	0	0	0	5,835	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	9,513	7,681	0	0	0	0	0	0	0	0	0	17,194	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,274	0	0	0	0	0	0	0	0	0	0	1,274	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	10,787	7,681	0	0	0	0	0	0	0	0	0	18,468	16
	C. General Administration													
17	Administrative	0	(353,811)	0	0	0	0	0	0	0	0	0	(353,811)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,421)	3,727	375	0	0	0	0	0	0	0	0	2,681	19
20	Fees, Subscriptions & Promotions	(74,750)	1,453	0	0	0	0	0	0	0	0	0	(73,297)	20
21	Clerical & General Office Expenses	6,083	87,110	0	0	0	0	0	0	0	0	0	93,193	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	8,031	0	0	0	0	0	0	0	0	0	8,031	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	2,579	0	0	0	0	0	0	0	0	0	2,579	26
27	Other (specify):*	(246,123)	0	0	0	0	0	0	0	0	0	0	(246,123)	27
28	TOTAL General Administration	(316,211)	(250,911)	375	0	(566,747)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(299,589)	(243,230)	375	0	(542,444)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE RIDGE CARE CENTRE# 0042366

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	(16,648)	4,127	122,796	0	0	0	0	0	0	0	0	110,275	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,061)	0	191,868	0	0	0	0	0	0	0	0	140,807	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	5,771	(312,000)	0	0	0	0	0	0	0	0	(306,229)	34
35	Rent-Equipment & Vehicles	0	5,195	0	0	0	0	0	0	0	0	0	5,195	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(67,709)	15,093	2,664	0	(49,952)	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)	(367,298)	(228,137)	3,039	0	(592,396)	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 HOMES		FIRST HEALTH CARE ASSOCIATES, LTD. (DIVISION OF FHC ENTERPRISE, INC.)	ROSEMONT, IL	MANAGEMENT/CONSULTANT
				LANDMARK PROPERTIES	ROSEMONT, IL	REAL ESTATE

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.		\$ 7,681	\$ 7,681	1
2	V	17 ADMINISTRATIVE	365,521	MR. BELLOWS OWNS 95% OF THIS FACILITY AND 100% OF FHC ENTERPRISES		11,710	(353,811)	2
3	V	19 PROFESSIONAL FEES				3,727	3,727	3
4	V	20 DUES & SUBSCRIPTIONS				1,453	1,453	4
5	V	21 CLERICAL				87,110	87,110	5
6	V	24 TRAVEL				8,031	8,031	6
7	V	26 INSURANCE				2,579	2,579	7
8	V	30 DEPRECIATION				4,127	4,127	8
9	V	34 RENT				5,771	5,771	9
10	V	35 RENT-EQUIPMENT & VEH.				5,195	5,195	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 365,521			\$ 137,384	\$ * (228,137)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$	LANDMARK PROPERTIES		\$ 375	\$ 375
16	V	30 DEPRECIATION-SL		" "		114,270	114,270
17	V	30 DEPRECIATION-SL		" "		8,526	8,526
18	V	32 INTEREST MORTGAGE		" "		188,117	188,117
19	V	32 AMORTIZATION - MTG COST		" "		3,751	3,751
20	V	34 RENT	312,000	" "			(312,000)
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 312,000			\$ 315,039	\$ * 3,039

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

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 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.	95.00	SEE ATTACHED	1.04	5.49	SALARY	11,710	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	\$ 11,710		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 RIDGE CARE CENTRE

0042366 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	\$ 41,736	7,681	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	41,736	11,710	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800	41,736	3,727	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462	41,736	1,453	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,659	41,736	10,871	5
6	21	CLERICAL	DIRECT COST	1	1	76,239	76,239	1	6
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528	41,736	8,031	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995	41,736	2,579	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603	41,736	4,127	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364	41,736	5,771	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	501,904	10	62,438	41,736	5,195	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					\$ 811,274	\$ 309,425	\$ 137,384	25

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

0042366

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											
										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	RELATED PARTY - LANDMARK PROPERTIES					\$	\$			\$	1									
2	AMERICAN NATIONAL BK		X	MORTGAGE	VARIES	11/96	2,980,000	2,215,400			188,117	2								
3	LOAN COST			LOAN COST							3,751	3								
4												4								
5												5								
Working Capital																				
6	AMERICAN NATIONAL BK		X	WORKING CAPITAL	DEMAND	VARIES	500,000	500,000	DEMAND	PRIME +	21,049	6								
7	RELATED FACILITIES	X		WORKING CAPITAL	DEMAND	DEMAND	783,000	1,430,964	DEMAND	PRIME +	140,849	7								
8												8								
9	TOTAL Facility Related						\$ 4,263,000	\$ 4,146,364			\$ 353,766	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14								
15	TOTALS (line 9+line14)						\$ 4,263,000	\$ 4,146,364			\$ 353,766	15								

* 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.		\$ 28,872	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.)		\$ 28,695	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (177)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 29,016	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.		\$ 28,839	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	29,035	8
	1997	29,260	9
	1998	29,229	10
	1999	29,063	11
	2000	28,695	12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL			
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 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

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 RIDGE CARE CENTRE COUNTY LOGAN

FACILITY IDPH LICENSE NUMBER 0042366

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>08-029-019-00</u>	<u>NURSING HOME</u>	\$ <u>28,694.58</u>	\$ <u>28,694.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>28,694.58</u>	\$ <u>28,694.58</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 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 RIDGE CARE CENTRE

0042366

Report Period Beginning:

01/01/2001 Ending:

12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,774 B. General Construction Type: Exterior MASONRY Frame STEEL/WOOD 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>170,750</u>	<u>1996</u>	<u>\$ 148,352</u>	1
2					2
3	TOTALS	170,750		\$ 148,352	3

Facility Name & ID Number MAPLE RIDGE CARE CENTRE# 0042366

Report Period Beginning:

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

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	120		1996		\$ 2,891,648	\$ 27,429	27.5	\$ 105,151	\$ 77,722	\$ 547,661	4
5			1997		15,792	574	27.5	574		2,692	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - LANDMARK PROPERTIES										
10	DINING ROOM REMODELING										
11	FENCE										
12	WALLCOVERING/TILE WORK										
13	INSTALLATION OF WALLCOVERING										
14	FLOOR TILES/INSTALLATION										
15	OUTDOOR SIGN										
16	WALLCOVERING/TILE WORK/INSTALLATION										
17	WALLCOVERING/DRYWALL/WINDOW FRAMES										
18	OUTDOOR SIGN										
19	PAVEMENT										
20	ADD LOUNGE, DINING, OFFICE & 10 BEDS										
21	REMODELING, OFFICE, ROOF CURB, DOORS										
22	WALLCOVERING, PAINTING										
23	PAINT & PREP ALL DOORS, BATHROOMS,KITCHEN,STORE RMS										
24	EDGE VENEER COUNTER TOPS										
25	REMOVE & INSTALL 105 SYSTEM RUBBER ROOFING										
26	REPLACE DAMAGED SOFFIT & FASCIA ON THE OUTSIDE										
27											
28											
29											
30											
31											
32											
33											
34											
35											
36											
					ADJ. TO SL	77,722			(77,722)		

*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)		\$ 3,104,208	\$ 114,270		\$ 114,270	\$ 0	\$ 570,953	70

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

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

0042366

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	\$ 238,229	\$ 31,940	\$ 18,657	\$ (13,283)	3-15YRS	\$ 78,213	71
72	Current Year Purchases	22,429	4,486	1,121	(3,365)	3-15 YRS	1,121	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTIES	131,473	12,653	12,653	0		67,216	74
75	TOTALS	\$ 392,131	\$ 49,079	\$ 32,431	\$ (16,648)		\$ 146,550	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	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,644,691	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 163,349	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 146,701	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,648)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 717,503	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: N/A RELATED PARTY

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</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: \$ 11,546 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

* 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.

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>FACILITY USE</u>	<u>98 DODGE DURANGO</u>	\$ <u>625.00</u>	\$ <u>7,525</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>625.00</u>	\$ <u>7,525</u>	21

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$ 219	\$ 549	\$	\$ 768
2 Books and Supplies	38	76		114
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	100			100
9 TOTALS	\$ 357	\$ 625	\$ 0	\$ 982
10 SUM OF line 9, col. 1 and 2 (e)	\$ 982			

- (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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	5

- (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	\$		\$ 67,997	\$		\$ 67,997	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,462			10,462	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			75,850			75,850	4
5	Physician Care	39-3	visits			1,986			1,986	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				77,047		77,047	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTAL, I.V. THERAPY Other (specify):	39-2					29,044		29,044	13
14	TOTAL			\$		\$ 156,295	\$ 106,091		\$ 262,386	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	\$ 454,309	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,283)	1,026,708		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,081		5
6	Prepaid Insurance	92,403		6
7	Other Prepaid Expenses	55,678		7
8	Accounts Receivable (owners or related parties)	416,057		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,046,236	\$ 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			15
16	Equipment, at Historical Cost	260,657		16
17	Accumulated Depreciation (book methods)	(168,240)		17
18	Deferred Charges	2,458		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			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)	\$ 94,875	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,141,111	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 164,362	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,198		28
29	Short-Term Notes Payable	500,000		29
30	Accrued Salaries Payable	49,518		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,505		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,016		32
33	Accrued Interest Payable	66		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	MANAGEMENT FEES	365,847		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,143,512	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,430,964		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)	\$ 1,430,964	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,574,476	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (433,365)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,141,111	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (460,374)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (460,372)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	27,007	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)	\$ 27,007	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)	\$ (433,365)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE# 0042366

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	\$ 4,617,489	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,617,489	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		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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income****	51,061	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 51,061	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	307	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 307	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,668,857	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	731,528	31
32	Health Care	1,418,288	32
33	General Administration	1,604,318	33
	B. Capital Expense		
34	Ownership	559,630	34
	C. Ancillary Expense		
35	Special Cost Centers	262,386	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,641,850	40
41	Income before Income Taxes (line 30 minus line 40)**	27,007	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 27,007	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	2,003	2,174	\$ 56,764	\$ 26.11	1
2	Assistant Director of Nursing	3,414	3,640	75,974	20.87	2
3	Registered Nurses	1,554	1,594	35,414	22.22	3
4	Licensed Practical Nurses	27,926	30,280	461,746	15.25	4
5	Nurse Aides & Orderlies	59,468	64,008	581,112	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,448	10,402	97,677	9.39	10
11	Social Service Workers	385	438	4,149	9.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,649	6,245	57,429	9.20	14
15	Cook Helpers/Assistants	13,210	13,938	88,229	6.33	15
16	Dishwashers					16
17	Maintenance Workers	2,132	2,373	38,646	16.29	17
18	Housekeepers	16,513	17,752	136,882	7.71	18
19	Laundry	3,655	3,737	22,672	6.07	19
20	Administrator	2,043	2,254	55,752	24.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,130	6,544	115,331	17.62	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)	153,530	165,379	\$ 1,827,777 *	\$ 11.05	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	179	\$ 10,127	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant	20	1,500	10-3	37
38	Nurse Consultant	160	5,515	10-3	38
39	Pharmacist Consultant	168	1,200	10-3	39
40	Physical Therapy Consultant	90	4,559	10a-3	40
41	Occupational Therapy Consultant	14	684	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	7	365	10a-3	43
44	Activity Consultant	34	2,150	11-3	44
45	Social Service Consultant	34	2,150	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	802	\$ 46,250		49

C. CONTRACT NURSES

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

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
					1	PAINT/DECORATING	1998	\$ 8,432	3	\$ 1,405	\$ 2,811	\$ 2,811	\$ 1,405
2	PAINT/DECORATING	1999	9,372	3		1,562	3,124	3,124	1,562				
3	PAINT/DECORATING	2000	1,366	3			228	455	455	228			
4	PAINT/DECORATING	2001	3,199	3				533	1,066	1,066	534		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 22,369		\$ 1,405	\$ 4,373	\$ 6,163	\$ 5,517	\$ 3,083	\$ 1,294	\$ 534	\$	\$

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

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? YES
If YES, give association name and amount. ILL. HEALTHCARE ASSOC. \$6484
- (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. \$ 0 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 _____ 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. \$ 65,700
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	10,127
	REPAIRS & MAINTENANCE	0
		0
		10,127
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	0
	ELECTRICITY	82,734
	WATER	30,032
	CABLE TV - LOBBY	784
		0
		113,550
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,346
	PAINTING & DECORATING	3,199
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,014
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	2,972
	EXTERMINATING SERVICE	3,339
	FIRE SERVICE	4,753
	DEFERRED MAINTENANCE	492
		0
		0
		25,115
7	OTHER	
	SCAVENGER	8,021
	SECURITY SERVICE	741
		8,762
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	18,000
		18,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,500
	PHARMACY CONSULTANT XVIII B 39-2	1,200
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	5,515
		0
		0
		8,215
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	80
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	4,559
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	684
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	365
		5,688
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,150
		0
		2,150
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,150
		0
		2,150
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	982
		982

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,429
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	365,521
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,209
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	145,827
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	159,036
	ENTERTAINMENT & MARKETING VI 19 XIX F	22,846
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	43,747
	EMPLOYEE WANT ADS XIX F	6,314
	CONTRIBUTIONS VI 20 XIX F	2,215
	DUES & SUBSCRIPTIONS XIX F	8,467
	LICENSES & PERMITS XIX F	312
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	5,942
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,440
21	CLERICAL & GENERAL OFFICE EXPENSES	91,283
	BANK CHARGES	820
	EQUIPMENT REPAIR & MAINTENANCE	3,201
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	229
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	4,905
	TELEPHONE	74,839
	MESSENGER SERVICE	381
		0
		84,375

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	139,793
	UNEMPLOYMENT COMPENSATION XIX D	22,629
	WORKERS COMPENSATION INSURANC XIX D	34,748
	HOSPITALIZATION INSURANCE XIX D	133,740
	EMPLOYEE BENEFITS - OTHER XIX D	32,751
	EMPLOYEE PHYSICAL EXAMS XIX D	2,059
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,087
	CHICAGO HEAD TAX XIX D	0
		370,807
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,744
		5,744
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	893
		0
		0
		893
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,065
		8,065
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	80,214
		80,214
27	OTHER	
	BAD DEBTS VI 24	246,123
		0
		246,123

GRAND TOTAL COLUMN 3 OTHER

1,608,229

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

TOTAL FOOD PURCHASE	160,320	PATIENT MEALS	125208
LESS SALES TAX	(727)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	161047	TOTAL MEALS/YEAR	125208
TOTAL PATIENT CENSUS	41,736	NET FOOD	161047
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	125208

TOTAL PATIENT MEALS	125208	COST PER MEAL	1.29
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

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

INCOME PER F/S									4,305,679	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,418,288	370,807	360,317	33,253	337,958	1,233,511	65,700	559,630		1,827,777
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	1,606		3,562			13,903		(19,071)		
CABLE TV			(784)			784				
CONTRACT NURSING/SALARIES REBILLED										8,113
INTEREST INCOME							(51,061)			
NET VENDING COMMISSIONS							(307)			
EMPLOYEE PHYSICAL EXAMS		(2,059)				2,059				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(365,521)		365,521		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(246,123)	246,123			
DISCOUNTS LOST							0			
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	0	0	0	0	0	0	(49,424)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	(71,616)	0	71,616		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	1,419,894	368,748	363,095	33,253	337,958	566,997	211,031	977,696	4,278,672	1,835,890
PER FINANCIAL STATEMENTS	1,419,894	368,748	363,095	33,253	337,958	566,997	211,031	977,696	27,007	1,835,890
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									27,007	

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

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		43,800			43920		(120)	43800			
CENSUS DAYS		41,736			42622		(886)	41533			
OCCUPANCY %		95.29%			97.04%			94.82%			
SALARIES											
TOTAL General Services	8-1	343,858	8.49%	8.24	358596	9.44%	8.41	(14,738)	336365	9.67%	8.10
Social Services	12-1	4,149	0.10%	0.10				4,149	11663	0.34%	0.28
TOTAL Health Care and Programs	16-1	1,312,836	32.42%	31.46	1240140	32.66%	29.10	72,696	1146450	32.95%	27.60
Clerical & General Office Expenses	21-1	115,331	2.85%	2.76	100662	2.65%	2.36	14,669	93746	2.69%	2.26
TOTAL General Administration	28-1	171,083	4.22%	4.10	166918	4.40%	3.92	4,165	181544	5.22%	4.37
TOTAL Operation Expense	29-1	1,827,777	45.14%	43.79	1765654	46.50%	41.43	62,123	1664359	47.84%	40.07
ADJUSTED TOTALS											
Food	2-8	159,593	3.94%	3.82	155384	4.09%	3.65	4,209	146750	4.22%	3.53
Heat and Other Utilities	5-8	113,550	2.80%	2.72	120837	3.18%	2.84	(7,287)	108786	3.13%	2.62
Maintenance	6-8	85,216	2.10%	2.04	77041	2.03%	1.81	8,175	76771	2.21%	1.85
TOTAL General Services	8-8	737,363	18.21%	17.67	744043	19.60%	17.46	(6,680)	707916	20.35%	17.04
Administrative	17-8	67,462	1.67%	1.62	80278	2.11%	1.88	(12,816)	102212	2.94%	2.46
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0			
Professional Services	19-8	161,717	3.99%	3.87	167601	4.41%	3.93	(5,884)	132900	3.82%	3.20
Fees, Subscriptions, Promotions	20-8	17,986	0.44%	0.43	10543	0.28%	0.25	7,443	14986	0.43%	0.36
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.01%	0.00	(200)	200	0.01%	0.00
License Fee-Other	Pg21	312	0.01%	0.01	761	0.02%	0.02	(449)	400	0.01%	0.01
Clerical & General Office Expenses	21-8	314,073	7.76%	7.53	280516	7.39%	6.58	33,557	250150	7.19%	6.02
Employee Benefits & Payroll Taxes	22-8	370,807	9.16%	8.88	331766	8.74%	7.78	39,041	239219	6.88%	5.76
Payroll Taxes	Pg21	162,422	4.01%	3.89	173368	4.57%	4.07	(10,946)	169536	4.87%	4.08
W/C Insurance	Pg21	34,748	0.86%	0.83	27323	0.72%	0.64	7,425	20372	0.59%	0.49
Health Insurance	Pg21	133,740	3.30%	3.20	95298	2.51%	2.24	38,442	35295	1.01%	0.85
Inservice Training & Education	23-8	5,744	0.14%	0.14	10560	0.28%	0.25	(4,816)	8182	0.24%	0.20
Travel and Seminar	24-8	8,924	0.22%	0.21	10718	0.28%	0.25	(1,794)	6555	0.19%	0.16
Other Admin. Staff Transportation	25-8	8,065	0.20%	0.19	18927	0.50%	0.44	(10,862)	20630	0.59%	0.50
Insurance-Prop.Liab.Malpractice	26-8	82,793	2.04%	1.98	54722	1.44%	1.28	28,071	29943	0.86%	0.72
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	1,037,571	25.62%	24.86	965631	25.43%	22.66	71,940	804777	23.13%	19.38
TOTAL Operation Expense	29-8	3,211,690	79.31%	76.95	3064631	80.71%	71.90	147,059	2776706	79.81%	66.86
Real Estate Taxes	33-3	28,839	0.71%	0.69	27873	0.73%	0.65	966	29205	0.84%	0.70
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	4,049,454	100.00%	97.03	3796983	100.00%	89.09	252,471	3479153	100.00%	83.77
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1508594.737	37.25%	36.15	1476652	38.89%	34.65	31,943	1347913	38.74%	32.45

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

This report reflects 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 5517 from Page 22 and -3199 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 DOES NOT EQUAL Page 9 Line 15-10. Diff=-191868

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=-126923

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

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

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.