

		FOR OHF USE					

LL1

**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

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><b>I. IDPH Facility ID Number:</b> <u>0044172</u></p> <p><b>Facility Name:</b> <u>MAPLECREST CARE CENTRE</u></p> <p><b>Address:</b> <u>4452 SQUAW PRAIRIE ROAD</u> <u>BELVIDERE</u> <u>61008</u>          Number City Zip Code</p> <p><b>County:</b> <u>BOONE</u></p> <p><b>Telephone Number:</b> <u>(815) 547-6377</u> Fax # <u>(815) 547-3857</u></p> <p><b>IDPA ID Number:</b> <u>36-4253834</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/99</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</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 border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <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 rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>SHAEL BELLOWS</u>			(Title) <u>MANAGEMENT CONSULTANT</u>		<b>Paid Preparer</b>	(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 &amp; 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>	
<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																																								
<b>IRS Exemption Code</b> _____	<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 _____																																									
<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>SHAEL BELLOWS</u>																																									
	(Title) <u>MANAGEMENT CONSULTANT</u>																																									
<b>Paid Preparer</b>	(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 &amp; 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>																																									

Facility Name & ID Number MAPLECREST CARE CENTRE

# 0044172 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	84	Skilled (SNF)	86	31,126	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	84	TOTALS	86	31,126	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	2,847	1,578	3,637	8,062	8
9	SNF/PED					9
10	ICF	13,404	6,648	1,277	21,329	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,251	8,226	4,914	29,391	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.43%

D. How many bed-hold days during this year were paid by Public Aid? 20 (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 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 86 and days of care provided 2,887

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number MAPLECREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**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
	<b>A. General Services</b>										
1	Dietary	157,346	6,853	8,161	172,360		172,360	642	173,002		1
2	Food Purchase		98,570		98,570		98,570	(1,048)	97,522		2
3	Housekeeping	43,681	15,180		58,861		58,861	382	59,243		3
4	Laundry	38,721	12,338	2,845	53,904		53,904	(612)	53,292		4
5	Heat and Other Utilities			91,643	91,643		91,643		91,643		5
6	Maintenance	49,131	16,673	29,286	95,090		95,090	818	95,908		6
7	Other (specify):*			3,684	3,684		3,684		3,684		7
8	<b>TOTAL General Services</b>	288,879	149,614	135,619	574,112		574,112	182	574,294		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	1,262,803	63,569	8,114	1,334,486		1,334,486	13,589	1,348,075		10
10a	Therapy	69,124		843	69,967		69,967		69,967		10a
11	Activities	70,729	2,290	904	73,923		73,923	(700)	73,223		11
12	Social Services	22,609		6,091	28,700		28,700		28,700		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,425,265	65,859	20,152	1,511,276		1,511,276	12,889	1,524,165		16
	<b>C. General Administration</b>										
17	Administrative	66,688		327,750	394,438		394,438	(324,968)	69,470		17
18	Directors Fees										18
19	Professional Services			106,813	106,813		106,813	2,831	109,644		19
20	Dues, Fees, Subscriptions & Promotions			26,675	26,675		26,675	(17,455)	9,220		20
21	Clerical & General Office Expenses	67,885	24,012	22,484	114,381		114,381	64,003	178,384		21
22	Employee Benefits & Payroll Taxes			295,432	295,432		295,432		295,432		22
23	Inservice Training & Education			3,991	3,991		3,991		3,991		23
24	Travel and Seminar							5,760	5,760		24
25	Other Admin. Staff Transportation			1,413	1,413		1,413		1,413		25
26	Insurance-Prop.Liab.Malpractice			126,443	126,443		126,443	2,880	129,323		26
27	Other (specify):*			24,000	24,000		24,000	(24,000)			27
28	<b>TOTAL General Administration</b>	134,573	24,012	935,001	1,093,586		1,093,586	(290,949)	802,637		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,848,717	239,485	1,090,772	3,178,974		3,178,974	(277,878)	2,901,096		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	7,050
	REPAIRS & MAINTENANCE	1,111
		0
		8,161
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,845
		0
		2,845
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	44,752
	ELECTRICITY	39,005
	WATER	6,627
	CABLE TV - LOBBY	1,259
		0
		91,643
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	13,895
	PAINTING & DECORATING	1,024
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,451
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,213
	FIRE SERVICE	703
		0
		0
		0
		29,286
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	3,481
	SECURITY SERVICE	203
		0
		3,684
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,200
		4,200

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	101
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	756
	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	6,321
		0
		0
		8,114
<b>10a</b>	<b>THERAPY</b>	
	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	602
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	241
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		843
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	904
		0
		904
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	6,091
		0
		6,091
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	327,750
<b>18</b>	<b>DIRECTORS FEES</b>	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	23,515
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	83,298
		0
		106,813
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	10,412
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,435
	EMPLOYEE WANT ADS XIX F	3,908
	CONTRIBUTIONS VI 20 XIX F	150
	DUES & SUBSCRIPTIONS XIX F	3,565
	LICENSES & PERMITS XIX F	670
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	572
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	610
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	353
		26,675
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,661
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	5,986
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	154
	TELEPHONE	14,593
	MESSENGER SERVICE	90
		0
		22,484

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	132,100
	UNEMPLOYMENT COMPENSATION XIX D	25,529
	WORKERS COMPENSATION INSURANCE XIX D	39,578
	HOSPITALIZATION INSURANCE XIX D	90,337
	EMPLOYEE BENEFITS - OTHER XIX D	3,108
	EMPLOYEE PHYSICAL EXAMS XIX D	1,180
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	3,600
	CHICAGO HEAD TAX XIX D	0
		295,432
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	3,991
		3,991
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,413
		1,413
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	126,443
		126,443
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	24,000
		0
		24,000

GRAND TOTAL COLUMN 3 OTHER

1,090,772

MAPLECREST CARE CENTRE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2003

TOTAL FOOD PURCHASE	98,570	PATIENT MEALS	88173
LESS SALES TAX	(1,048)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	97,522	TOTAL MEALS/YEAR	88173
TOTAL PATIENT CENSUS	29,391	NET FOOD	97522
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	88173
	-----		
TOTAL PATIENT MEALS	88173	COST PER MEAL	1.11
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number MAPLECREST CARE CENTRE

#0044172

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			58,336	58,336		58,336	(20,548)	37,788			30
31	Amortization of Pre-Op. & Org.			10,000	10,000		10,000		10,000			31
32	Interest			92,607	92,607		92,607	(10,058)	82,549			32
33	Real Estate Taxes			32,208	32,208		32,208		32,208			33
34	Rent-Facility & Grounds			87,500	87,500		87,500	9,140	96,640			34
35	Rent-Equipment & Vehicles			12,329	12,329		12,329	3,853	16,182			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			292,980	292,980		292,980	(17,613)	275,367			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,530	166,158	245,688		245,688		245,688			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,689	46,689		46,689		46,689			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		79,530	212,847	292,377		292,377		292,377			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,848,717	319,015	1,596,599	3,764,331		3,764,331	(295,491)	3,468,840			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	(22,371)	30		9
10	Interest and Other Investment Income	(10,058)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,048)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,986)	21		18
19	Entertainment	(10,412)	20		19
20	Contributions	(760)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(548)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(6,435)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(572)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	2,481			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (79,709)		\$	30

<b>OHF USE ONLY</b>					
48		49		50	
				51	
					52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(215,782)	PG 6	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (215,782)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (295,491)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

MAPLECREST CARE CENTRE

ID# 0044172

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 525	6	1
2	VACATION ACCRUAL	642	1	2
3	VACATION ACCRUAL	382	3	3
4	VACATION ACCRUAL	(612)	4	4
5	VACATION ACCRUAL	293	6	5
6	VACATION ACCRUAL	7,935	10	6
7	VACATION ACCRUAL	(700)	11	7
8	VACATION ACCRUAL	(6,542)	17	8
9	VACATION ACCRUAL	558	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
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	2,481		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLECREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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	642	0	0	0	0	0	0	0	0	0	0	642	1
2	Food Purchase	(1,048)	0	0	0	0	0	0	0	0	0	0	(1,048)	2
3	Housekeeping	382	0	0	0	0	0	0	0	0	0	0	382	3
4	Laundry	(612)	0	0	0	0	0	0	0	0	0	0	(612)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	818	0	0	0	0	0	0	0	0	0	0	818	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>182</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>182</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	7,935	5,654	0	0	0	0	0	0	0	0	0	13,589	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(700)	0	0	0	0	0	0	0	0	0	0	(700)	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	<b>TOTAL Health Care and Programs</b>	<b>7,235</b>	<b>5,654</b>	<b>0</b>	<b>12,889</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	(6,542)	(318,426)	0	0	0	0	0	0	0	0	0	(324,968)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(548)	3,379	0	0	0	0	0	0	0	0	0	2,831	19
20	Fees, Subscriptions & Promotions	(18,179)	724	0	0	0	0	0	0	0	0	0	(17,455)	20
21	Clerical & General Office Expenses	(5,428)	69,431	0	0	0	0	0	0	0	0	0	64,003	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	5,760	0	0	0	0	0	0	0	0	0	5,760	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	2,880	0	0	0	0	0	0	0	0	0	2,880	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	<b>TOTAL General Administration</b>	<b>(54,697)</b>	<b>(236,252)</b>	<b>0</b>	<b>(290,949)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(47,280)</b>	<b>(230,598)</b>	<b>0</b>	<b>(277,878)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLECREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(22,371)	1,823	0	0	0	0	0	0	0	0	0	(20,548)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,058)	0	0	0	0	0	0	0	0	0	0	(10,058)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,140	0	0	0	0	0	0	0	0	0	9,140	34
35	Rent-Equipment & Vehicles	0	3,853	0	0	0	0	0	0	0	0	0	3,853	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(32,429)</b>	<b>14,816</b>	<b>0</b>	<b>(17,613)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(79,709)</b>	<b>(215,782)</b>	<b>0</b>	<b>(295,491)</b>	<b>45</b>								

**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 ENTERPRISES, INC.)	MORTON GROVE	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.		\$ 5,654	\$ 5,654	1
2	V	17 ADMINISTRATIVE	327,750	MR. BELLOWS OWNS 67.5% OF THIS FACILITY		9,324	(318,426)	2
3	V	19 PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		3,379	3,379	3
4	V	20 DUES & SUBSCRIPTIONS		" "		724	724	4
5	V	21 CLERICAL		" "		69,431	69,431	5
6	V	24 TRAVEL		" "		5,760	5,760	6
7	V	26 INSURANCE		" "		2,880	2,880	7
8	V	30 DEPRECIATION		" "		1,823	1,823	8
9	V	34 RENT		" "		9,140	9,140	9
10	V	35 RENT-EQUIPMENT & VEH.		" "		3,853	3,853	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 327,750			\$ 111,968	\$ * (215,782)	14

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

Facility Name &amp; ID Number

MAPLECREST CARE CENTRE

# 0044172

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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.	67.5%	SEE ATTACHED	1.41	5.95	SALARY	9,324	17-7	2
3	EMANUEL BINSTOCK	MNGMT CNSLT.	ADMIN.	5%	NONE	1.34	5.98	SALARY	8,039	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,363		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 MAPLECREST CARE CENTRE

# 0044172 Report Period Beginning: 01/01/2003

Ending: 2/31/2003

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

Name of Related Organization FHC ENTERPRISES, INC.  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

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

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	493,454	9	\$ 94,929	\$ 29,391	\$ 5,654	1
2	17	ADMINISTRATIVE	PATIENT DAYS	493,454	9	159,981	29,391	9,324	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	493,454	9	56,724	29,391	3,379	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	493,454	9	12,155	29,391	724	4
5	21	CLERICAL	PATIENT DAYS	493,454	9	191,338	29,391	11,396	5
6	21	CLERICAL	DIRECT COST	1	58,035	58,035	1	58,035	6
7	24	TRAVEL	PATIENT DAYS	493,454	9	96,702	29,391	5,760	7
8	26	INSURANCE	PATIENT DAYS	493,454	9	48,361	29,391	2,880	8
9	30	DEPRECIATION	PATIENT DAYS	493,454	9	30,611	29,391	1,823	9
10	34	RENT	PATIENT DAYS	493,454	9	153,459	29,391	9,140	10
11	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	493,454	9	64,696	29,391	3,853	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					\$ 966,991	\$ 312,945	\$ 111,968	25

Facility Name & ID Number

MAPLECREST CARE CENTRE

# 0044172

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	MEMBER LOANS	X		WORKING CAPITAL	DEMAND	VARIES	150,000	216,554	DEMAND	0.0775	15,576	6						
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	721,000	1,041,597	DEMAND	VARIES	77,031	7						
8												8						
9	TOTAL Facility Related						\$ 871,000	\$ 1,258,151			\$ 92,607	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 871,000	\$ 1,258,151			\$ 92,607	15						

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	\$	<b>30,048</b>	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.)	\$	<b>30,960</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>912</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>31,296</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>32,208</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998		8
	1999	<b>42,234</b>	9
	2000	<b>48,238</b>	10
	2001	<b>46,974</b>	11
	2002	<b>30,960</b>	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 2002 TAX BILL.**

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	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:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 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.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME MAPLECREST 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 2002 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 2002.

	(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>30,960.00</u>	\$ <u>30,960.00</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>30,960.00</u>	\$ <u>30,960.00</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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number MAPLECREST CARE CENTRE

# 0044172

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

**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:**

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

Facility Name & ID Number **MAPLECREST CARE CENTRE**# **0044172**

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

**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
	<b>Improvement Type**</b>										
9		WALL COVERING/BORDERS/VINYL COVERINGS		1999	17,944	2,563	7	2,563		12,057	9
10		STEEL DOORS		1999	2,337	85	27.5	85		395	10
11		SIGN, SIGN FOOTINGS AND BRICKS		1999	4,652	169	27.5	169		697	11
12		REMODEL-DINING & REC RM., OFFICES, HALLS		1999	73,951	2,690	27.5	2,690		11,320	12
13		CONDENSING UNIT FOR WALK IN FREEZER		2000	3,695	134	27.5	134		419	13
14		WATER SOFTENER UNIT		2000	10,120	368	27.5	368		1,150	14
15		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS		2001	11,239	409	27.5	409		1,210	15
16		TWO HOT WATER HEATERS		2001	13,065	475	27.5	475		1,405	16
17		REMOVAL OF WATER TANKS & PIPING		2001	7,650	278	27.5	278		799	17
18		REPAIRS TO GRAVEL ROOF		2001	2,875	105	27.5	105		275	18
19		BLACKTOP PARKING LOT		2001	1,270	46	27.5	46		121	19
20		AIRCONDITIONING - REPAIRS & INSTALLATION - DINING RM.		2001	7,430	270	27.5	270		686	20
21		ASBESTOS ABATEMENT/FLOOR RENOVATION		2001	1,400	51	27.5	51		128	21
22		REPLACE WATER COIL - FOOD STORAGE AREA		2001	7,500	273	27.5	273		648	22
23		INSTALL CONTROL DAMPER IN BATHING AREA		2001	1,795	65	27.5	65		144	23
24		BOILER ROOM EXHAUST FAN		2001	1,980	72	27.5	72		159	24
25		REPLACE DAMPER ON GENERATOR		2001	1,260	46	27.5	46		98	25
26		ADDITION OF 6 BEDS - GENERAL CONSTR/WINDOWS/PAINTING		2001	103,815	3,775	27.5	3,775		8,022	26
27		EXHAUST FANS FOR KITCHEN & DISHWASHING AREA		2001	5,894	214	27.5	214		455	27
28		AIR CONDITIONING CONDENSING UNIT		2002	8,557	311	27.5	311		518	28
29		ROOF REPAIR OVER LAUNDRY RM. RMS 212 & 114, FOYER		2002	9,800	356	27.5	356		534	29
30		ROOF REPAIRS		2002	2,030	74	27.5	74		86	30
31		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS		2003	5,607	102	27.5	102		102	31
32		CONSTRUCTION OF 2 BED ADDITION - FROM 84 BEDS TO 86		2003	76,097	1,384	27.5	1,384		1,384	32
33		ROOF REPAIRS - IN THE VALLEY, LAUNDRY RM & BEAUTY SAL		2003	4,627	84	27.5	84		84	33
34		NEW A/C UNIT IN DINING ROOM		2003	16,997	309	27.5	309		309	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

**XI. OWNERSHIP COSTS (continued)**

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 403,587	\$ 14,708		\$ 14,708	\$	\$ 43,205	70

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

**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	\$ 217,308	\$ 34,148	\$ 19,532	\$ (14,616)	3-15 YRS	\$ 61,166	71
72	Current Year Purchases	19,312	9,480	1,725	(7,755)	3-15 YRS	1,725	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>		1,823	1,823				74
75	<b>TOTALS</b>	\$ 236,620	\$ 45,451	\$ 23,080	\$ (22,371)		\$ 62,891	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 640,207	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,159	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,788	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,371)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 106,096	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	<b>TOTALS</b>	\$	\$	\$	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?  YES  NO

If NO, see instructions.

		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:		<u>78</u>	<u>02/01/99</u>	\$ <u>87,500</u>			3
4	Additions	<u>12/11/2001</u>	<u>6</u>					4
5		<u>5/13/2003</u>	<u>2</u>					5
6								6
7	TOTAL		<u>86</u>		\$ <u>87,500</u>			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**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: \$ 9,875 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	<u>ADMINISTRATIVE</u>	<u>2003 HONDA CIVIC</u>	\$ <u>229.00</u>	\$ <u>2,454</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>229.00</u>	\$ <u>2,454</u>	21

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. 12/31/2004 \$ 91,650

13. 12/31/2005 \$ 91,800

14. 12/31/2006 \$ 93,636

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

**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**

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

- (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.

- (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	\$		\$ 75,152	\$		\$ 75,152	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,082			6,082	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			84,924			84,924	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				69,818		69,818	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY & Other (specify): <b>RENTALS</b>	39-2					9,712		9,712	13
14	<b>TOTAL</b>			\$		\$ 166,158	\$ 79,530		\$ 245,688	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.

Facility Name &amp; ID Number MAPLECREST CARE CENTRE

# 0044172

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 66,344	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 17,081 )	536,131		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,624		6
7	Other Prepaid Expenses	4,471		7
8	Accounts Receivable (owners or related parties)	204,692		8
9	Other(specify): <b>EMPLOYEE LOANS</b>	913		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 843,175	\$	10
	<b>B. Long-Term Assets</b>			
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	403,587		15
16	Equipment, at Historical Cost	236,618		16
17	Accumulated Depreciation (book methods)	(212,427)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	50,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(49,167)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 428,611	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,271,786	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 110,605	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,264		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,541		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,996		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,296		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>MANAGEMENT FEES</b>	5,457		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 294,159	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,258,151		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,258,151	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,552,310	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (280,524)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,271,786	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(379,803)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>DEPRECIATION ADJ:</b>	<b>(2,719)</b>	<b>3</b>
<b>4</b>	<b>ROUNDING ADJ</b>	<b>(4)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(382,526)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>402,002</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(300,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>102,002</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(280,524)</b>	<b>24</b> *

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

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,156,275	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,156,275	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	10,058	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,058	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>NET VENDING COMMISSIONS</b>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,166,333	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	574,112	31
32	Health Care	1,511,276	32
33	General Administration	1,093,586	33
	<b>B. Capital Expense</b>		
34	Ownership	292,980	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	245,688	35
36	Provider Participation Fee	46,689	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,764,331	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	402,002	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 402,002	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.

Facility Name & ID Number MAPLECREST CARE CENTRE

# 0044172

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**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	2,378	2,378	\$ 85,171	\$ 35.82	1
2	Assistant Director of Nursing	1,303	1,311	33,863	25.83	2
3	Registered Nurses	11,793	12,199	289,383	23.72	3
4	Licensed Practical Nurses	9,885	10,225	197,840	19.35	4
5	Nurse Aides & Orderlies	47,818	50,361	547,743	10.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,833	4,232	69,124	16.33	8
9	Activity Director	1,829	1,990	27,480	13.81	9
10	Activity Assistants	4,906	5,196	43,249	8.32	10
11	Social Service Workers	1,532	1,737	22,609	13.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,584	4,974	66,110	13.29	14
15	Cook Helpers/Assistants	11,203	11,769	91,236	7.75	15
16	Dishwashers					16
17	Maintenance Workers	3,423	3,588	49,131	13.69	17
18	Housekeepers	5,854	6,155	43,681	7.10	18
19	Laundry	5,316	5,490	38,721	7.05	19
20	Administrator	1,980	2,053	66,688	32.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,021	4,319	67,885	15.72	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	5,245	5,739	108,803	18.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,903	133,716	\$ 1,848,717 *	\$ 13.83	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	158	\$ 7,050	1-3	35
36	Medical Director	24	4,200	9-3	36
37	Medical Records Consultant	16	756	10-3	37
38	Nurse Consultant	153	6,321	10-3	38
39	Pharmacist Consultant	96	936	10-3	39
40	Physical Therapy Consultant	12	602	10a-3	40
41	Occupational Therapy Consultant	6	241	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	15	904	11-3	44
45	Social Service Consultant	104	6,091	12-3	45
46	Other(specify) <u>PSYCHO SOCIAL</u>	2	101	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	586	\$ 27,202		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	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	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003
1	PAINTING/DECORATING	06/2001	\$ 1,577	3	\$	\$ 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 &amp; ID Number MAPLECREST CARE CENTRE

# 0044172

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**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. ILL. COUNCIL ON LTC - \$4536
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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. \$ 2,141 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. \$ 46,689  
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? \_\_\_\_\_ 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