

		FOR OHF USE					

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**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)**

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 NORTH KICKAPOO STREET</u> <u>LINCOLN</u> <u>62656</u> Number City Zip Code</p> <p>County: <u>LOGAN</u></p> <p>Telephone Number: <u>(217) 735-1538</u> Fax # <u>(217) 732-4818</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 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>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>01/01/2005</u> to <u>12/31/2005</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%;">Officer or Administrator of Provider</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%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, 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: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 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 PARTNER</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, 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: 01/01/2005 Ending: 12/31/2005

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,278	793	4,526	9,597	8
9	SNF/PED					9
10	ICF	25,042	4,645	26	29,713	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,320	5,438	4,552	39,310	14

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

D. How many bed-hold days during this year were paid by the Department? 0 (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 32 and days of care provided 2,601

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	159,283	21,408	9,786	190,477		190,477	64	190,541		1
2	Food Purchase		151,412		151,412		151,412	(1,595)	149,817		2
3	Housekeeping	157,288	18,895		176,183		176,183	794	176,977		3
4	Laundry	13,406	10,820	78	24,304		24,304	(302)	24,002		4
5	Heat and Other Utilities			123,680	123,680		123,680		123,680		5
6	Maintenance	56,332	35,540	38,935	130,807		130,807	675	131,482		6
7	Other (specify):*			14,914	14,914		14,914		14,914		7
8	TOTAL General Services	386,309	238,075	187,393	811,777		811,777	(364)	811,413		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,334,999	108,713	70,620	1,514,332		1,514,332	(45,277)	1,469,055		10
10a	Therapy			966	966		966		966		10a
11	Activities	108,937	7,501	2,698	119,136		119,136	(987)	118,149		11
12	Social Services			2,698	2,698		2,698		2,698		12
13	CNA Training			108	108		108		108		13
14	Program Transportation			889	889		889		889		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,443,936	116,214	95,979	1,656,129		1,656,129	(46,264)	1,609,865		16
	C. General Administration										
17	Administrative	73,117		380,945	454,062		454,062	(380,945)	73,117		17
18	Directors Fees										18
19	Professional Services			315,506	315,506		315,506	(228,242)	87,264		19
20	Dues, Fees, Subscriptions & Promotions			147,814	147,814		147,814	(113,138)	34,676		20
21	Clerical & General Office Expenses	136,420	25,033	64,655	226,108		226,108	149,492	375,600		21
22	Employee Benefits & Payroll Taxes			344,908	344,908		344,908		344,908		22
23	Inservice Training & Education			7,012	7,012		7,012		7,012		23
24	Travel and Seminar			150	150		150	6,308	6,458		24
25	Other Admin. Staff Transportation			11,005	11,005		11,005		11,005		25
26	Insurance-Prop.Liab.Malpractice			108,655	108,655		108,655	22,402	131,057		26
27	Other (specify):*			35,975	35,975		35,975	(35,975)			27
28	TOTAL General Administration	209,537	25,033	1,416,625	1,651,195		1,651,195	(580,098)	1,071,097		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,039,782	379,322	1,699,997	4,119,101		4,119,101	(626,726)	3,492,375		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
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	9,786
	REPAIRS & MAINTENANCE		0
			0
			9,786
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		78
			0
			78
5	HEAT & OTHER UTILITIES		
	GAS HEAT		0
	ELECTRICITY		85,443
	WATER		35,259
	CABLE TV - LOBBY		2,978
			0
			123,680
6	MAINTENANCE		
	GROUNDS MAINTENANCE		7,700
	PAINTING & DECORATING		7,434
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		7,957
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		2,726
	EXTERMINATING SERVICE		7,270
	FIRE SERVICE		5,848
			0
			0
			0
			38,935
7	OTHER		
	SCAVENGER		14,065
	SECURITY SERVICE		849
			14,914
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		207
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	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	69,213
			0
			0
			70,620
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	966
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			966
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,698
			0
			2,698
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	2,698
			0
			2,698
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	108
			108

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	889
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	380,945
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	25,929
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	289,577
		0
		315,506
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	48,687
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	46,175
	EMPLOYEE WANT ADS XIX F	15,535
	CONTRIBUTIONS VI 20 XIX F	1,640
	DUES & SUBSCRIPTIONS XIX F	13,940
	LICENSES & PERMITS XIX F	1,663
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	14,321
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,957
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,896
		147,814
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,433
	EQUIPMENT REPAIR & MAINTENANCE	67
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,069
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	253
	TELEPHONE	53,196
	MESSENGER SERVICE	3,637
		0
		64,655

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	154,227
	UNEMPLOYMENT COMPENSATION XIX D	27,580
	WORKERS COMPENSATION INSURANCE XIX D	52,867
	HOSPITALIZATION INSURANCE XIX D	95,895
	EMPLOYEE BENEFITS - OTHER XIX D	9,298
	EMPLOYEE PHYSICAL EXAMS XIX D	1,817
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	3,224
	CHICAGO HEAD TAX XIX D	0
		344,908
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	7,012
		7,012
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	150
		0
		0
		150
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,005
		11,005
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	108,655
		108,655
27	OTHER	
	BAD DEBTS VI 24	35,975
		35,975

GRAND TOTAL COLUMN 3 OTHER 1,699,997

MAPLE RIDGE CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	151,412	PATIENT MEALS	117930
LESS SALES TAX	(1,595)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	149,817	TOTAL MEALS/YEAR	117930
TOTAL PATIENT CENSUS	39,310	NET FOOD	149817
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	117930

TOTAL PATIENT MEALS	117930	COST PER MEAL	1.27
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

#0042366

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			53,858	53,858		53,858	151,580	205,438			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			220,592	220,592		220,592	218,024	438,616			32
33	Real Estate Taxes			37,780	37,780		37,780		37,780			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(514,514)	25,486			34
35	Rent-Equipment & Vehicles			31,075	31,075		31,075	8,579	39,654			35
36	Other (specify):* STORAGE			1,922	1,922		1,922		1,922			36
37	TOTAL Ownership			885,227	885,227		885,227	(136,331)	748,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,629	263,625	383,254		383,254		383,254			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		119,629	329,325	448,954		448,954		448,954			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,039,782	498,951	2,914,549	5,453,282		5,453,282	(763,057)	4,690,225			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	(16,483)	30		9
10	Interest and Other Investment Income	(50,225)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,595)	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	(2,069)	21		18
19	Entertainment	(48,687)	20		19
20	Contributions	(4,597)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(159)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,975)	27		24
25	Fund Raising, Advertising and Promotional	(46,175)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,321)	20		28
29	Other-Attach Schedule	(9,635)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (229,921)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(533,136)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (533,136)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (763,057)		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

MAPLE RIDGE CARE CENTRE

ID# 0042366

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 544	6	1
2	VACATION ACCRUAL	64	1	2
3	VACATION ACCRUAL	794	3	3
4	VACATION ACCRUAL	(302)	4	4
5	VACATION ACCRUAL	131	6	5
6	VACATION ACCRUAL	(10,702)	10	6
7	VACATION ACCRUAL	(987)	11	7
8	VACATION ACCRUAL	823	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
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,635)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE RIDGE CARE CENTRE# 0042366

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	64	0	0	0	0	0	0	0	0	0	0	64	1
2	Food Purchase	(1,595)	0	0	0	0	0	0	0	0	0	0	(1,595)	2
3	Housekeeping	794	0	0	0	0	0	0	0	0	0	0	794	3
4	Laundry	(302)	0	0	0	0	0	0	0	0	0	0	(302)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	675	0	0	0	0	0	0	0	0	0	0	675	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(364)	0	0	0	0	0	0	0	0	0	0	(364)	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	(10,702)	0	0	(34,575)	0	0	0	0	0	0	0	(45,277)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(987)	0	0	0	0	0	0	0	0	0	0	(987)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA 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	(11,689)	0	0	(34,575)	0	0	0	0	0	0	0	(46,264)	16
	C. General Administration													
17	Administrative	0	0	(285,709)	0	0	(95,236)	0	0	0	0	0	(380,945)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(159)	5,351	(21,633)	947	(212,748)	0	0	0	0	0	0	(228,242)	19
20	Fees, Subscriptions & Promotions	(113,780)	0	190	189	263	0	0	0	0	0	0	(113,138)	20
21	Clerical & General Office Expenses	(1,246)	0	42,397	1,404	106,937	0	0	0	0	0	0	149,492	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	0	1,318	3,265	1,725	0	0	0	0	0	0	6,308	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	18,137	1,605	1,329	1,331	0	0	0	0	0	0	22,402	26
27	Other (specify):*	(35,975)	0	0	0	0	0	0	0	0	0	0	(35,975)	27
28	TOTAL General Administration	(151,160)	23,488	(261,832)	7,134	(102,492)	(95,236)	0	0	0	0	0	(580,098)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(163,213)	23,488	(261,832)	(27,441)	(102,492)	(95,236)	0	0	0	0	0	(626,726)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE RIDGE CARE CENTRE# 0042366

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(16,483)	168,063	0	0	0	0	0	0	0	0	0	151,580	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(50,225)	268,249	0	0	0	0	0	0	0	0	0	218,024	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(540,000)	0	790	24,696	0	0	0	0	0	0	(514,514)	34
35	Rent-Equipment & Vehicles	0	0	4,204	2,894	1,481	0	0	0	0	0	0	8,579	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(66,708)	(103,688)	4,204	3,684	26,177	0	0	0	0	0	0	(136,331)	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)	(229,921)	(80,200)	(257,628)	(23,757)	(76,315)	(95,236)	0	0	0	0	0	(763,057)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		MAPLE RIDGE, LLC		
					MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED BUSINESS ENTITIES		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 540,000	MAPLE RIDGE, LLC		\$	(540,000)	1
2	V	19 ACCOUNTING FEES		" "		5,196	5,196	2
3	V	19 PROFESSIONAL FEES		" "		155	155	3
4	V	26 MORTGAGE INSURANCE		" "		18,137	18,137	4
5	V	30 DEPRECIATION - BLDG/IMP		" "		99,695	99,695	5
6	V	30 DEPRECIATION - EQPT		" "		68,368	68,368	6
7	V	32 AMORTIZATION - MTG COST		" "		3,138	3,138	7
8	V	32 INTEREST - MORTGAGE		" "		241,685	241,685	8
9	V	32 INTEREST - OTHER		" "		23,426	23,426	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 540,000			\$ 459,800	\$ * (80,200)	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	\$ 30,084	YORK MANAGEMENT ASSOCIATES, LLC		\$ 8,451	\$ (21,633)
16	V	20 DUES & SUBSCRIPTIONS		"		190	190
17	V	21 CLERICAL		"		42,397	42,397
18	V	24 TRAVEL		"		1,318	1,318
19	V	26 INSURANCE		"		1,605	1,605
20	V	35 RENT - EQPT & VEH.		"		4,204	4,204
21	V	17 ADMINISTRATIVE	285,709	"			(285,709)
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		\$ 315,793			\$ 58,165	\$ * (257,628)

* 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	10 NURSING	\$ 69,213	CARLYLE NURSING ASSOCIATES, LLC		\$ 34,638	\$ (34,575)
16	V	19 PROFESSIONAL FEES		"		947	947
17	V	20 DUES & SUBSCRIPTIONS		"		189	189
18	V	21 CLERICAL		"		1,404	1,404
19	V	24 TRAVEL		"		3,265	3,265
20	V	26 INSURANCE		"		1,329	1,329
21	V	30 DEPRECIATION		"			
22	V	34 RENT		"		790	790
23	V	35 RENT - EQPT & VEH.		"		2,894	2,894
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		\$ 69,213			\$ 45,456	\$ * (23,757)

* 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	\$ 215,923	THE KENSINGTON GROUP, LLC		\$ 3,175	\$ (212,748)
16	V	20 DUES & SUBSCRIPTIONS		"		263	263
17	V	21 CLERICAL		"		106,937	106,937
18	V	24 TRAVEL		"		1,725	1,725
19	V	26 INSURANCE		"		1,331	1,331
20	V	30 DEPRECIATION		"			
21	V	34 RENT		"		24,696	24,696
22	V	35 RENT - EQPT & VEH		"		1,481	1,481
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		\$ 215,923			\$ 139,608	\$ * (76,315)

* 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	17 ADMINISTRATIVE	\$ 95,236	CHESTERFIELD, LLC		\$	\$ (95,236) 15
16	V						
17	V						
18	V						
19	V						
20	V						
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		\$ 95,236			\$ 0	\$ * (95,236) 39

* 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: 01/01/2005 Ending: 12/31/2005

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 YORK MANAGEMENT ASSOC. LLC
 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	155,033	3	\$ 33,323	\$ 39,310	\$ 8,451	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	155,033	3	750	39,310	190	2
3	21	CLERICAL	PATIENT DAYS	155,033	3	167,179	161,657	42,397	3
4	24	TRAVEL	PATIENT DAYS	155,033	3	5,198	39,310	1,318	4
5	26	INSURANCE	PATIENT DAYS	155,033	3	6,327	39,310	1,605	5
6	35	RENT - EQPT & VEH.	PATIENT DAYS	155,033	3	16,576	39,310	4,204	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 229,353	\$ 161,657	\$ 58,165	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 CARLYLE NURSING ASSOCIATES, LLC
 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	DIRECT HOURS	1	\$ 34,638	\$ 34,638	1	\$ 34,638	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	11,646		39,310	947	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	2,323		39,310	189	3
4	21	CLERICAL	PATIENT DAYS	483,650	17,276		39,310	1,404	4
5	24	TRAVEL	PATIENT DAYS	483,650	40,167		39,310	3,265	5
6	26	INSURANCE	PATIENT DAYS	483,650	16,351		39,310	1,329	6
7	30	DEPRECIATION	PATIENT DAYS	483,650			39,310		7
8	34	RENT	PATIENT DAYS	483,650	9,715		39,310	790	8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	483,650	35,603		39,310	2,894	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	TOTALS				\$ 167,719	\$ 34,638		\$ 45,456	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning:

01/01/2005

Ending: 2/31/2005

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 THE KENSINGTON GROUP, LLC
 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	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	\$ 39,055	\$ 39,310	\$ 3,175	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	3,234	39,310	263	2
3	21	CLERICAL	PATIENT DAYS	483,650	9	1,315,340	39,310	106,937	3
4	24	TRAVEL	PATIENT DAYS	483,650	9	21,213	39,310	1,725	4
5	26	INSURANCE	PATIENT DAYS	483,650	9	16,374	39,310	1,331	5
6	30	DEPRECIATION	PATIENT DAYS	483,650	9		39,310		6
7	34	RENT	PATIENT DAYS	483,650	9	303,769	39,310	24,696	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	483,650	9	18,215	39,310	1,481	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	TOTALS					\$ 1,717,200	\$ 1,150,879	\$ 139,608	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY - MAPLE RIDGE, LLC						\$	\$			\$	1						
2	GMAC MORTGAGE COST		X	MORTGAGE		07/2002	3,715,350	3,612,726	07/2037	6.6600	241,685	2						
3	LOAN COST		X	LOAN COST - AMORT 35 YEARS			74,246	62,671			3,138	3						
4												4						
5												5						
Working Capital																		
6	CHESTERFIELD	X		WORKING CAPITAL	DEMAND	12/04	150,000	649,360	DEMAND	VARIES	10,975	6						
7	LANDMARK	X		WORKING CAPITAL	DEMAND	DEMAND	450,000	3,764,980	DEMAND	VARIES	230,738	7						
8	LETTER OF CREDIT FEE		X								2,305	8						
9	TOTAL Facility Related						\$ 4,389,596	\$ 8,089,737			\$ 488,841	9						
B. Non-Facility Related*																		
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)						\$ 4,389,596	\$ 8,089,737			\$ 488,841	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2004 report.		\$	34,476	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.)		\$	35,932	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,456	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	36,324	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	37,780	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	28,695	8
	2001	29,586	9
	2002	33,607	10
	2003	34,100	11
	2004	35,932	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 2004 TAX BILL.

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

(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>35,932.48</u>	\$ <u>35,932.48</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>35,932.48</u>	\$ <u>35,932.48</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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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, CNA 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>	<u>1</u>
2					<u>2</u>
3	TOTALS	170,750		\$ 148,352	3

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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		\$ 2,496,225	\$ 90,772	27.5	\$ 90,772	\$	\$ 835,858	4
5		1997		15,792	574	27.5	574		4,856	5
6										6
7										7
8										8
	Improvement Type**									
9	RELATED PARTY - MAPLERIDGE LLC									9
10	DINING ROOM REMODELING		1997	7,441	271	27.5	271		2,290	10
11	FENCE		1997	4,300	156	27.5	156		1,321	11
12	WALLCOVERING/TILE WORK		1997	11,399	415	27.5	415		3,508	12
13	INSTALLATION OF WALLCOVERING		1997	10,590	385	27.5	385		3,257	13
14	FLOOR TILES/INSTALLATION		1997	1,160	42	27.5	42		356	14
15	OUTDOOR SIGN		1997	10,880	396	27.5	396		3,348	15
16	WALLCOVERING/TILE WORK/INSTALLATION		1998	30,545	1,111	27.5	1,111		8,285	16
17	WALLCOVERING/DRYWALL/WINDOW FRAMES		1999	31,471	1,144	27.5	1,144		7,390	17
18	OUTDOOR SIGN		1999	4,190	152	27.5	152		983	18
19	PAVEMENT		1999	6,230	227	27.5	227		1,464	19
20	REMODELING, OFFICE, ROOF CURB, DOORS		2000	22,801	829	27.5	829		4,525	20
21	WALLCOVERING, PAINTING		2000	3,683	134	27.5	134		731	21
22	PAINT & PREP ALL DOORS, BATHROOMS, KITCHEN,STORE RM		2001	13,835	503	27.5	503		2,243	22
23	EDGE VENEER COUNTER TOPS		2001	1,028	37	27.5	37		166	23
24	REMOVE & INSTALL I05 SYSTEM RUBBER ROOFING		2001	9,880	359	27.5	359		1,601	24
25	REPLACE DAMAGED SOFFIT & FASCIA ON THE OUTSIDE		2001	2,486	90	27.5	90		402	25
26	TEAR OUT AND REBUILD SECTION OF ASPHALT PRKG LOT		2002	4,477	163	27.5	163		564	26
27	EXTEND 2 WALLS TO ROOF DECK & DRYWALL COVER		2002	4,034	147	27.5	147		508	27
28	NURSING STATION - CALL LIGHT SYSTEM		2002	28,723	1,044	27.5	1,044		3,611	28
29	RUN ELECTRICITY OUT TO THE PAVILLION		2002	1,396	51	27.5	51		177	29
30	RAISE FLOORS IN 4 ROOMS, ALONG OUTSIDE WALL		2003	3,570	130	27.5	130		287	30
31	REPAIR ASPHALT - ENTIRE PARKING LOT		2003	8,545	311	27.5	311		687	31
32	INSTALL ROOF TOP UNIT		2003	6,918	252	27.5	252		556	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			2,741,599		99,695		99,695	888,974

**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:

01/01/2005

Ending:

12/31/2005

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	\$ 342,547	\$ 25,221	\$ 30,216	\$ 4,995	3-10 YRS	\$ 163,224	71
72	Current Year Purchases	143,185	28,637	7,159	(21,478)	3-10 YRS	7,159	72
73	Fully Depreciated Assets	21,057						73
74	RELATED PARTIES		68,368	68,368				74
75	TOTALS	\$ 506,789	\$ 122,226	\$ 105,743	\$ (16,483)		\$ 170,383	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	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,396,740	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 221,921	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,438	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,483)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,059,357	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	6 BED ADDITIONS	\$ 281,955	92
93			93
94			94
95		\$ 281,955	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 Original Lease Date	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

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: \$ 27,533 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>FACILITY USE</u>	<u>99 DODGE DURANGO</u>	\$ <u>295.13</u>	\$ <u>3,542</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 295.13	\$ 3,542	21

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. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 68	\$	\$ 68
2	Books and Supplies		40		40
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 108	\$	\$ 108
10	SUM OF line 9, col. 1 and 2 (e)	\$	108		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 82,593	\$		\$ 82,593	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			74,451			74,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			98,355			98,355	4
5	Physician Care	39-3	visits			5,436			5,436	5
6	Dental Care	39-3	visits			2,790			2,790	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				81,081		81,081	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, I.V. THERAPY & Other (specify): RENTAL	39-2					38,548		38,548	13
14	TOTAL			\$		\$ 263,625	\$ 119,629		\$ 383,254	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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	\$ 35,630	\$ 508,651	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,013,869	1,013,869	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,664	106,788	6
7	Other Prepaid Expenses	28,094	28,094	7
8	Accounts Receivable (owners or related parties)	156,309	265,687	8
9	Other(specify): ESCROW DEPOSITS		1,148,013	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,264,566	\$ 3,071,102	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,195,537	968,826	11
12	Long-Term Investments			12
13	Land		585,600	13
14	Buildings, at Historical Cost		3,318,321	14
15	Leasehold Improvements, at Historical Cost		309,653	15
16	Equipment, at Historical Cost	488,250	1,351,925	16
17	Accumulated Depreciation (book methods)	(347,025)	(2,392,237)	17
18	Deferred Charges	3,590	104,672	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): CONST. IN PROGRESS		281,955	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,340,352	\$ 4,528,715	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,604,918	\$ 7,599,817	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 209,747	\$ 209,747	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,191	54,191	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,333	78,333	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,191	32,751	31
32	Accrued Real Estate Taxes(Sch.IX-B)		36,324	32
33	Accrued Interest Payable	52,235	32,340	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 404,697	\$ 443,686	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,598,283	1,465,417	39
40	Mortgage Payable		5,826,977	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)	\$ 3,598,283	\$ 7,292,394	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,002,980	\$ 7,736,080	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,398,062)	\$ (136,263)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,604,918	\$ 7,599,817	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (741,250)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	8	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (741,242)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(656,820)	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)	\$ (656,820)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,398,062)	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,746,237	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,746,237	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)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	50,225	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50,225	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,796,462	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	811,777	31
32	Health Care	1,656,129	32
33	General Administration	1,651,195	33
	B. Capital Expense		
34	Ownership	885,227	34
	C. Ancillary Expense		
35	Special Cost Centers	383,254	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,453,282	40
41	Income before Income Taxes (line 30 minus line 40)**	(656,820)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (656,820)	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 MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	1,965	2,078	\$ 61,994	\$ 29.83	1
2	Assistant Director of Nursing	1,384	1,416	34,284	24.21	2
3	Registered Nurses	2,553	2,702	66,710	24.69	3
4	Licensed Practical Nurses	28,628	31,914	550,528	17.25	4
5	CNAs & Orderlies	58,258	63,347	590,627	9.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,050	2,281	26,969	11.82	9
10	Activity Assistants	6,826	7,565	81,968	10.84	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,539	8,230	74,324	9.03	14
15	Cook Helpers/Assistants	11,556	12,380	84,959	6.86	15
16	Dishwashers					16
17	Maintenance Workers	3,225	3,482	56,332	16.18	17
18	Housekeepers	17,592	18,777	157,288	8.38	18
19	Laundry	1,987	2,059	13,406	6.51	19
20	Administrator	2,045	2,270	73,117	32.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,379	8,248	136,420	16.54	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	2,238	2,446	30,856	12.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,225	169,195	\$ 2,039,782 *	\$ 12.06	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	165	\$ 9,786	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	562	69,213	10-3	38
39	Pharmacist Consultant	96	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	2	966	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	44	2,698	11-3	44
45	Social Service Consultant	44	2,698	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,009	\$ 104,561		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Certified Nurse Assistants/Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MICHELLE EYRSE	ADMIN		\$ 73,117	Workers' Compensation Insurance	\$ 52,867	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	27,580	Advertising: Employee Recruitment	15,535	
				FICA Taxes	154,227	Health Care Worker Background Check	2,896	
				Employee Health Insurance	95,895	(Indicate # of checks performed)		
				Employee Meals	0	MARKETING/ADV/PROMO	109,183	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,597	
				EMPLOYEE BENEFITS - OTHER	9,298	LICENSES & PERMITS	1,663	
				EMPLOYEE PHYSICAL EXAMS	1,817	DUES & SUBSCRIPTIONS	13,940	
				PENSION/PROFIT SHARING PLANS	3,224	MGMT CO ALLOCATION	642	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,597)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(48,687)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(46,175)	
						Yellow page advertising	(14,321)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,117	TOTAL (agree to Schedule V, line 22, col.8)	\$ 344,908	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,676	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CHESTERFIELD LLC MANAGEMENT FEES			\$ 285,709				Out-of-State Travel	\$
YORK MANAGEMENT ASSOC. MANAGEMENT FEES			95,236					
							In-State Travel	
							TRAVEL	150
							RELATED PARTY	6,308
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 380,945	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,458
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			315,506					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 315,506					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13														
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
																	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
1	PAINT/DECORATING	06/2002	\$ 12,265	3	\$ 2,044	\$ 4,088	\$ 4,088	\$ 2,045	\$	\$	\$	\$														
2	PAINT/DECORATING	06/2003	7,519	3		1,253	2,506	2,506	1,254																	
3	PAINT/DECORATING	06/2004	6,565	3			1,094	2,188	2,188	1,095																
4	PAINT/DECORATING	06/2005	7,434					1,239	2,478	2,478	1,239															
5																										
6																										
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20	TOTALS		\$ 33,783		\$ 2,044	\$ 5,341	\$ 7,688	\$ 7,978	\$ 5,920	\$ 3,573	\$ 1,239	\$														

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

0042366

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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. \$7200.00
- (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. \$ 1,715 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 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, 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. \$ N/A
- (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