

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	86	Skilled (SNF)	86	31,390	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	86	TOTALS	86	31,390	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	2,593	2,637	3,942	9,172	8
9	SNF/PED					9
10	ICF	10,169	10,342	610	21,121	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,762	12,979	4,552	30,293	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.51%

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 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 3,563

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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	178,755	12,243	9,276	200,274		200,274	(769)	199,505		1
2	Food Purchase		125,120		125,120	0	125,120	(1,410)	123,710		2
3	Housekeeping	46,306	17,212	0	63,518		63,518	(806)	62,712		3
4	Laundry	48,563	5,996	3,271	57,830	0	57,830	(763)	57,067		4
5	Heat and Other Utilities			107,645	107,645		107,645	0	107,645		5
6	Maintenance	60,028	22,818	29,860	112,706		112,706	(657)	112,049		6
7	Other (specify):*			4,081	4,081		4,081	0	4,081		7
8	TOTAL General Services	333,652	183,389	154,133	671,174	0	671,174	(4,405)	666,769		8
	B. Health Care and Programs										
9	Medical Director	0		4,800	4,800		4,800	0	4,800		9
10	Nursing and Medical Records	1,469,309	67,870	50,743	1,587,922		1,587,922	(22,965)	1,564,957		10
10a	Therapy	67,820		0	67,820		67,820	0	67,820		10a
11	Activities	87,480	7,399	2,832	97,711		97,711	(346)	97,365		11
12	Social Services	0		5,811	5,811		5,811	0	5,811		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			378	378		378	0	378		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,624,609	75,269	64,564	1,764,442	0	1,764,442	(23,311)	1,741,131		16
	C. General Administration										
17	Administrative	72,594		379,699	452,293		452,293	(382,410)	69,883		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			208,095	208,095		208,095	(91,578)	116,517		19
20	Dues, Fees, Subscriptions & Promotions			61,202	61,202		61,202	(45,223)	15,979		20
21	Clerical & General Office Expenses	72,003	24,875	21,249	118,127		118,127	90,065	208,192		21
22	Employee Benefits & Payroll Taxes			341,361	341,361	0	341,361	0	341,361		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			2,106	2,106		2,106	5,653	7,759		24
25	Other Admin. Staff Transportation			6,691	6,691		6,691	0	6,691		25
26	Insurance-Prop.Liab.Malpractice			148,982	148,982		148,982	3,183	152,165		26
27	Other (specify):*			23,785	23,785		23,785	(23,785)	0		27
28	TOTAL General Administration	144,597	24,875	1,193,170	1,362,642	0	1,362,642	(444,095)	918,547		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,102,858	283,533	1,411,867	3,798,258	0	3,798,258	(471,811)	3,326,447		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	7,308
	REPAIRS & MAINTENANCE	1,968
		0
		9,276
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,271
		0
		3,271
5	HEAT & OTHER UTILITIES	
	GAS HEAT	60,415
	ELECTRICITY	39,286
	WATER	7,944
	CABLE TV - LOBBY	0
		0
		107,645
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,789
	PAINTING & DECORATING	374
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	20,732
	ELEVATOR MAINTENANCE & REPAIR	765
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,628
	FIRE SERVICE	1,572
		0
		0
		0
		0
		29,860
7	OTHER	
	SCAVENGER	3,848
	SECURITY SERVICE	233
		0
		0
		4,081
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,800
		4,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	860
	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	48,947
		0
		0
		50,743
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	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	1,241
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,591
		0
		2,832
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,811
		0
		5,811
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	378
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	379,699
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	24,571
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	183,524
		0
		208,095
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	41,056
	EMPLOYEE WANT ADS XIX F	5,267
	CONTRIBUTIONS VI 20 XIX F	150
	DUES & SUBSCRIPTIONS XIX F	4,944
	LICENSES & PERMITS XIX F	2,888
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,823
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,059
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	415
	PATIENT BACKGROUND CHECKS XIX F	1,600
		61,202
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,621
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,015
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	3,089
	TELEPHONE	13,452
	MESSENGER SERVICE	2,072
		0
		21,249

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	151,457
	UNEMPLOYMENT COMPENSATION XIX D	19,317
	WORKERS COMPENSATION INSURANC XIX D	46,841
	HOSPITALIZATION INSURANCE XIX D	115,063
	EMPLOYEE BENEFITS - OTHER XIX D	2,989
	EMPLOYEE PHYSICAL EXAMS XIX D	1,680
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	4,014
	CHICAGO HEAD TAX XIX D	0
		0
		341,361
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,106
	TRAVEL XIX G	0
		2,106
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	6,691
		6,691
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	148,982
		148,982
27	OTHER	
	BAD DEBTS VI 24	23,785
		23,785

GRAND TOTAL COLUMN 3 OTHER

1,411,867

MAPLE CREST CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	125,120	PATIENT MEALS	90879
LESS SALES TAX	(1,410)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	123,710	TOTAL MEALS/YEAR	90879
TOTAL PATIENT CENSUS	30,293	NET FOOD	123710
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	90879

TOTAL PATIENT MEALS	90879	COST PER MEAL	1.36
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

MAPLE CREST CARE CENTRE

#0044172

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	
	D. Ownership											
30	Depreciation			74,727	74,727		74,727	(9,640)	65,087			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			66,951	66,951		66,951	(19,358)	47,593			32
33	Real Estate Taxes			32,130	32,130		32,130	0	32,130			33
34	Rent-Facility & Grounds			84,095	84,095		84,095	18,703	102,798			34
35	Rent-Equipment & Vehicles			11,747	11,747		11,747	4,090	15,837			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			269,650	269,650	0	269,650	(6,205)	263,445			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		92,454	227,016	319,470		319,470	0	319,470			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			47,085	47,085		47,085	0	47,085			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	92,454	274,101	366,555	0	366,555	0	366,555			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,102,858	375,987	1,955,618	4,434,463	0	4,434,463	(478,016)	3,956,447			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	(11,658)	30		9
10	Interest and Other Investment Income	(9,679)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,410)	2		13
14	Non-Care Related Interest	(9,679)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(1,015)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,209)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(6,123)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,785)	27		24
25	Fund Raising, Advertising and Promotional	(41,056)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,823)	20		28
29	Other-Attach Schedule	(12,654)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (122,091)		\$ 0	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(355,925)	PG 6-6C	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (355,925)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (478,016)		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

BHF USE ONLY

48	49	50	51	52
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MAPLE CREST CARE CENTRE

ID# 0044172

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	VACATION ACCRUAL	(769)	1	2
3	VACATION ACCRUAL	(806)	3	3
4	VACATION ACCRUAL	(763)	4	4
5	VACATION ACCRUAL	(657)	6	5
6	VACATION ACCRUAL	(1,679)	10	6
7	VACATION ACCRUAL	(346)	11	7
8	VACATION ACCRUAL	(3,074)	17	8
9	VACATION ACCRUAL	(110)	21	9
10	MEDICAL SUPPLY CO. (MED B. BILLING)	(550)	19	10
11	PINNACLE CONSULTING(ADVERTISING)	(3,900)	19	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	(12,654)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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	(769)	0	0	0	0	0	0	0	0	0	0	(769)	1
2	Food Purchase	(1,410)	0	0	0	0	0	0	0	0	0	0	(1,410)	2
3	Housekeeping	(806)	0	0	0	0	0	0	0	0	0	0	(806)	3
4	Laundry	(763)	0	0	0	0	0	0	0	0	0	0	(763)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(657)	0	0	0	0	0	0	0	0	0	0	(657)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,405)	0	0	0	0	0	0	0	0	0	0	(4,405)	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	(1,679)	0	(21,286)	0	0	0	0	0	0	0	0	(22,965)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(346)	0	0	0	0	0	0	0	0	0	0	(346)	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	(2,025)	0	(21,286)	0	0	0	0	0	0	0	0	(23,311)	16
	C. General Administration													
17	Administrative	(3,074)	(284,770)	0	363	(94,929)	0	0	0	0	0	0	(382,410)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,573)	36,780	361	(118,146)	0	0	0	0	0	0	0	(91,578)	19
20	Fees, Subscriptions & Promotions	(46,088)	253	327	285	0	0	0	0	0	0	0	(45,223)	20
21	Clerical & General Office Expenses	(1,125)	1,243	2,137	87,810	0	0	0	0	0	0	0	90,065	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	1,658	1,979	2,016	0	0	0	0	0	0	0	5,653	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,425	999	759	0	0	0	0	0	0	0	3,183	26
27	Other (specify):*	(23,785)	0	0	0	0	0	0	0	0	0	0	(23,785)	27
28	TOTAL General Administration	(84,645)	(243,411)	5,803	(26,913)	(94,929)	0	0	0	0	0	0	(444,095)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,075)	(243,411)	(15,483)	(26,913)	(94,929)	0	0	0	0	0	0	(471,811)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(11,658)	232	106	1,680	0	0	0	0	0	0	0	(9,640)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,358)	0	0	0	0	0	0	0	0	0	0	(19,358)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	878	17,825	0	0	0	0	0	0	0	18,703	34
35	Rent-Equipment & Vehicles	0	1,627	1,219	1,244	0	0	0	0	0	0	0	4,090	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,016)	1,859	2,203	20,749	0	0	0	0	0	0	0	(6,205)	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)	(122,091)	(241,552)	(13,280)	(6,164)	(94,929)	0	0	0	0	0	0	(478,016)	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 ATACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		SEE ATTACHED LIST OF 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:	
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	17 ADMINISTRATIVE	\$ 284,770	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		\$	(284,770)	1
2	V	19 PROFESSIONAL FEES		"		36,780	36,780	2
3	V	20 DUES & SUBSCRIPTIONS		"		253	253	3
4	V	21 CLERICAL		"		1,243	1,243	4
5	V	24 TRAVEL		"		1,658	1,658	5
6	V	26 INSURANCE		"		1,425	1,425	6
7	V	35 RENT - EQPT & VEHICLES		"		1,627	1,627	7
8	V	30 DEPRECIATION		"		232	232	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 284,770			\$ 43,218	\$ * (241,552)	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	10 NURSING	\$ 48,449	CARLYLE NURSING ASSOCIATES, LLC		\$ 27,163	\$ (21,286)
16	V	19 PROFESSIONAL FEES		"		361	361
17	V	20 DUES & SUBSCRIPTIONS		"		327	327
18	V	21 CLERICAL		"		2,137	2,137
19	V	24 TRAVEL		"		1,979	1,979
20	V	26 INSURANCE		"		999	999
21	V	30 DEPRECIATION		"		106	106
22	V	34 RENT		"		878	878
23	V	35 RENT - EQPT & VEH		"		1,219	1,219
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		\$ 48,449			\$ 35,169	\$ * (13,280)

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

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 119,558	THE KENSINGTON GROUP, LLC		\$ 1,412	\$ (118,146)
16	V	20 DUES & SUBSCRIPTIONS		"		285	285
17	V	21 CLERICAL		"		87,810	87,810
18	V	24 TRAVEL		"		2,016	2,016
19	V	26 INSURANCE		"		759	759
20	V	30 DEPRECIATION		"		1,680	1,680
21	V	34 RENT		"		17,825	17,825
22	V	35 RENT - EQPT & VEH		"		1,244	1,244
23	V	17 ADMINISTRATIVE		"		363	363
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		\$ 119,558			\$ 113,394	\$ * (6,164)

* 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	\$ 94,929	CHESTERFIELD, LLC		\$	\$ (94,929)
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		\$ 94,929			\$ 0	\$ * (94,929)

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

Facility Name & ID Number

MAPLE CREST CARE CENTRE

#

0044172

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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 CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WITTINGHAM 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

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	345,796	7	\$ 419,864	\$ 30,293	\$ 36,780	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	345,796	7	2,888	30,293	253	2
3	21	CLERICAL	PATIENT DAYS	345,796	7	14,195	30,293	1,243	3
4	24	TRAVEL	PATIENT DAYS	345,796	7	18,932	30,293	1,658	4
5	26	INSURANCE	PATIENT DAYS	345,796	7	16,262	30,293	1,425	5
6	35	RENT - EQPT & VEH.	PATIENT DAYS	345,796	7	18,569	30,293	1,627	6
7	17	ADMINISTRATIVE	PATIENT DAYS	345,796	7	0	30,293	0	7
8	30	DEPRECIATION	PATIENT DAYS	345,796	7	2,647	30,293	232	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					\$ 493,357	\$	\$ 43,218	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 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	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	\$ 27,163	\$ 27,163	1	\$ 27,163	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	6,221	30,293	361	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	5,639	30,293	327	3
4	21	CLERICAL	PATIENT DAYS	522,604	11	36,838	30,293	2,137	4
5	24	TRAVEL	PATIENT DAYS	522,604	11	34,123	30,293	1,979	5
6	26	INSURANCE	PATIENT DAYS	522,604	11	17,224	30,293	999	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	11	1,834	30,293	106	7
8	34	RENT	PATIENT DAYS	522,604	11	15,145	30,293	878	8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	522,604	11	21,023	30,293	1,219	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				\$ 165,210	\$ 27,163		\$ 35,169	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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	522,604	11	\$ 24,352	\$ 30,293	\$ 1,412	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	4,910	30,293	285	2
3	21	CLERICAL	PATIENT DAYS	522,604	11	162,920	30,293	9,444	3
4	24	TRAVEL	PATIENT DAYS	522,604	11	34,777	30,293	2,016	4
5	26	INSURANCE	PATIENT DAYS	522,604	11	13,097	30,293	759	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	11	28,982	30,293	1,680	6
7	34	RENT	PATIENT DAYS	522,604	11	307,494	30,293	17,825	7
8	35	RENT - EQPT & VEH.	PATIENT DAYS	522,604	11	21,468	30,293	1,244	8
9	17	ADMINISTRATIVE	DIRECT HOURS	1	1	363	1	363	9
10	21	CLERICAL	DIRECT HOURS	1	1	78,366	1	78,366	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					\$ 676,729	\$	\$ 113,394	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	MEMBER LOANS	X		WORKING CAPITAL	DEMAND	VARIES	150,000	270,906	DEMAND	0.0775	19,485									
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	721,000	543,910	DEMAND	VARIES	47,466									
8	LETTER OF CREDIT FEE		X																	
9	TOTAL Facility Related						\$ 871,000	\$ 814,816			\$ 66,951									
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES																
11																				
12																				
13																				
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0									
15	TOTALS (line 9+line14)						\$ 871,000	\$ 814,816			\$ 66,951									

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 2005 report.	\$	31,224	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.)	\$	31,506	2
3. Under or (over) accrual (line 2 minus line 1).	\$	282	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	31,848	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.	\$	32,130	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	46,974	8
	2002	30,960	9
	2003	29,862	10
	2004	30,884	11
	2005	31,506	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE 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 2005 TAX BILL.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAPLE CREST CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044172

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>31,506.14</u>	\$ <u>31,506.14</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>31,506.14</u>	\$ <u>31,506.14</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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:

A. Land.

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

Facility Name & ID Number **MAPLE CREST CARE CENTRE**# **0044172**

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		WALL COVERING/BORDERS/VINYL COVERINGS		1999	17,944	760	7	760		17,943	9
10		STEEL DOORS		1999	2,337	85	27.5	85		650	10
11		SIGN, SIGN FOOTINGS AND BRICKS		1999	4,652	169	27.5	169		1,204	11
12		REMODEL - DINING & REC. ROOMS, OFFICES, HALLS		1999	73,951	2,690	27.5	2,690		19,390	12
13		CONDENSING UNIT FOR WALK IN FREEZER		2000	3,695	134	27.5	134		821	13
14		WATER SOFTENER UNIT		2000	10,120	368	27.5	368		2,254	14
15		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS		2001	11,239	409	27.5	409		2,437	15
16		TWO HOT WATER HEATERS		2001	13,065	475	27.5	475		2,830	16
17		REMOVAL OF WATER TANKS & PIPING		2001	7,650	278	27.5	278		1,633	17
18		REPAIRS TO GRAVEL ROOF		2001	2,875	105	27.5	105		590	18
19		BLACKTOP PARKING LOT		2001	1,270	46	27.5	46		259	19
20		AIRCONDITIONING - REPAIRS & INSTALLATION - DINING RM.		2001	7,430	270	27.5	270		1,496	20
21		ASBESTOS ABATEMENT/FLOOR RENOVATION		2001	1,400	51	27.5	51		281	21
22		REPLACE WATER COIL - FOOD STORAGE AREA		2001	7,500	273	27.5	273		1,467	22
23		INSTALL CONTROL DAMPER IN BATHING AREA		2001	1,795	65	27.5	65		339	23
24		BOILER ROOM EXHAUST FAN		2001	1,980	72	27.5	72		375	24
25		REPLACE DAMPER ON GENERATOR		2001	1,260	46	27.5	46		236	25
26		ADDITION OF 6 BEDS - GENERAL CONST./WINDOWS/PAINTING		2001	103,815	3,775	27.5	3,775		19,347	26
27		EXHAUST FANS FOR KITCHEN & DISHWASHING AREA		2001	5,894	214	27.5	214		1,097	27
28		AIR CONDITIONING CONDENSING UNIT		2002	8,557	311	27.5	311		1,451	28
29		ROOF REPAIR OVER LAUNDRY RM, RMS 212 & 114 & FOYER		2002	9,800	356	27.5	356		1,602	29
30		ROOF REPAIRS		2002	2,030	74	27.5	74		308	30
31		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS		2003	5,607	204	27.5	204		714	31
32		CONSTRUCTION OF 2 BED ADDITON - FROM 84 BEDS TO 86		2003	76,097	2,767	27.5	2,767		9,685	32
33		ROOF REPAIRS IN THE VALLEY, LAUNDRY RM & BEAUTY SALC		2003	4,627	168	27.5	168		588	33
34		NEW A/C UNIT IN DINING ROOM		2003	16,997	618	27.5	618		2,163	34
35		25 TON BRYANT CONDENSING UNIT - OFFICE AREA		2004	10,620	386	27.5	386		998	35
36		ELECTRICAL REPAIRS ON CONDUITS IN KITCHEN FLOOR		2004	4,407	160	27.5	160		387	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	2	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	REMOVE OLD TILE AND INSTALL NEW ONES IN KITCHEN	2004	\$ 1,400	\$ 51	27.5	\$ 51	\$	\$ 123	37
38	REPLACE EXISTING SEWER LINE/REPLACE SINK FAUCET								38
39	REPAIR DRAIN LINE & PIPE CONCRETE WALL - KITCHEN	2004	10,000	364	27.5	364		880	39
40	KITCHEN TILES - BEHIND DISHWASHER AND SINKS	2005	1,500	55	27.5	55		110	40
41	WALLCOVERINGS, DRAPES, CUBICLE CURTAINS - RES. RMS	2006	41,904	8,381	5	8,381		8,381	41
42	CORRIDOR CEILING UPGRADES	2006	23,625	609	27.5	609		609	42
43	REMOVE & INSTALL TILES & HAND RAILS - 100,200 WINGS	2006	45,000	886	27.5	886		886	43
44	REPAIR DOORS, INSTALL CARPET & WALL PAPER - 100 WING	2006	20,000	4,000	5	4,000		4,000	44
45	INSTALL 5 EXTERIOR WALL PACKS FLOOD LAMPS	2006	1,714	34	27.5	34		34	45
46	INSTALL 460' DECO SHIELD FOR NEW PIPING	2006	4,388	86	27.5	86		86	46
47	INSTALL SEWAGE PUMP	2006	7,391	123	27.5	123		123	47
48	REPLACED FIRE ALARM PANEL	2006	4,730	50	27.5	50		50	48
49	NEW NURSES WORK STATIONS & SECURITY CAMERAS	2006	11,486	122	27.5	122		122	49
50	VCT FLOORING FOR NURSES STATIONS & REC. ROOM	2006	2,533	19	27.5	19		19	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)		\$ 594,285	\$ 30,109		\$ 30,109	\$ 0	\$ 107,968	70

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

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

0044172

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 283,212	\$ 32,530	\$ 29,938	\$ (2,592)	10 YRS	\$ 143,873	71
72	Current Year Purchases	60,441	12,088	3,022	(9,066)	10 YRS	3,022	72
73	Fully Depreciated Assets	31,555			0			73
74	RELATED PARTY		2,018	2,018	0			74
75	TOTALS	\$ 375,208	\$ 46,636	\$ 34,978	\$ (11,658)		\$ 146,895	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 969,493	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 76,745	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,087	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,658)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 254,863	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: COUNTY OF BOONE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	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>84,095</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>84,095</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: \$ 8,999 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>2,748</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>229.00</u>	\$ <u>2,748</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. 12/31/2007 \$ 94,769

13. 12/31/2008 \$ 98,561

14. 12/31/2009 \$ 101,187

* 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 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>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 CNA _____</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 CNA _____</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	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$		\$ 96,221	\$		\$ 96,221	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			23,427			23,427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			107,368			107,368	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				81,200		81,200	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): RENTALS	39-2					11,254		11,254	13
14	TOTAL			\$		\$ 227,016	\$ 92,454		\$ 319,470	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 CREST CARE CENTRE

0044172

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 208,422	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,039)	884,343		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,324		6
7	Other Prepaid Expenses	14,548		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,143,637	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	232,475		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	594,285		15
16	Equipment, at Historical Cost	375,208		16
17	Accumulated Depreciation (book methods)	(401,140)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 800,828	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,944,465	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 172,792	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	112,689		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,470		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,057		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,848		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	51,347		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 484,203	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	814,816		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 814,816	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,299,019	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 645,446	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,944,465	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 366,647	1
2	Restatements (describe):		2
3	ROUNDING ADJ	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 366,648	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	278,798	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)	\$ 278,798	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 645,446	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	\$ 4,703,552	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,703,552	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	30	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)	\$ 30	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,679	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,679	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,713,261	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	671,174	31
32	Health Care	1,764,442	32
33	General Administration	1,362,642	33
	B. Capital Expense		
34	Ownership	269,650	34
	C. Ancillary Expense		
35	Special Cost Centers	319,470	35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,434,463	40
41	Income before Income Taxes (line 30 minus line 40)**	278,798	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 278,798	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 CREST CARE CENTRE

0044172

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	2,015	2,041	\$ 84,670	\$ 41.48	1
2	Assistant Director of Nursing	1,900	2,085	58,802	28.20	2
3	Registered Nurses	12,679	13,952	365,118	26.17	3
4	Licensed Practical Nurses	10,477	11,068	239,020	21.60	4
5	CNAs & Orderlies	53,506	57,548	627,430	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,584	3,980	67,820	17.04	8
9	Activity Director	1,937	2,086	32,177	15.43	9
10	Activity Assistants	5,660	6,039	55,303	9.16	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	8,280	8,965	113,190	12.63	14
15	Cook Helpers/Assistants	8,127	8,525	65,565	7.69	15
16	Dishwashers					16
17	Maintenance Workers	3,870	4,095	60,028	14.66	17
18	Housekeepers	6,355	6,593	46,306	7.02	18
19	Laundry	6,152	6,551	48,563	7.41	19
20	Administrator	1,955	2,086	72,594	34.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,731	4,061	72,003	17.73	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	3,853	4,239	94,269	22.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,081	143,914	\$ 2,102,858 *	\$ 14.61	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	156	\$ 7,308	1-3	35
36	Medical Director	24	4,800	9-3	36
37	Medical Records Consultant	16	860	10-3	37
38	Nurse Consultant	510	48,947	10-3	38
39	Pharmacist Consultant	96	936	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	25	1,591	11-3	44
45	Social Service Consultant	95	5,811	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	922	\$ 70,253		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	Certified Nurse Assistants/Aides			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	
MARIE HARTZOG	ADMINISTRATOR		\$ 72,594	Workers' Compensation Insurance	\$ 46,841	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	19,317	Advertising: Employee Recruitment	5,267	
				FICA Taxes	151,457	Health Care Worker Background Check	415	
				Employee Health Insurance	115,063	(Indicate # of checks performed <u>55</u>)		
				Employee Meals	0	Patient Background Checks	160	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,209	
				EMPLOYEE BENEFITS - OTHER	2,989	MARKETING/ADV/PROMO	42,879	
				EMPLOYEE PHYSICAL EXAMS	1,680	LICENSES/DUES/SUBSCRIPTIONS	7,832	
				PENSION/PROFIT SHARING PLANS	4,014	MGMT CO ALLOC	865	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,209)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(41,056)	
						Yellow page advertising	(1,823)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,594	TOTAL (agree to Schedule V, line 22, col.8)	\$ 341,361	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,979	
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
WITTINGHAM MANAGEMENT ASSOC. LLC MNGMT FEE			\$ 284,770				Out-of-State Travel	\$
CHESTERFIELD LLC MANAGEMENT FEE			94,929					
							In-State Travel	
							TRAVEL	0
							RELATED PARTY	5,653
							Seminar Expense	2,106
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 379,699	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 7,759
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			208,095					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 208,095					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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. 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. \$ 1,898 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. \$ 47,085
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