

Facility Name & ID Number MAPLE RIDGE CARE CENTER

0042366 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 01/06/06

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>95</u>	Skilled (SNF)	<u>101</u>	<u>36,835</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>25</u>	Intermediate (ICF)	<u>25</u>	<u>9,125</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>126</u>	<u>45,960</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,670</u>	<u>1,031</u>	<u>5,941</u>	<u>12,642</u>	8
9	SNF/PED					9
10	ICF	<u>22,512</u>	<u>4,095</u>	<u>205</u>	<u>26,812</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,182</u>	<u>5,126</u>	<u>6,146</u>	<u>39,454</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.84%

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 4,235

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 RIDGE CARE CENTER # 0042366 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	166,712	19,605	10,923	197,240		197,240	(225)	197,015		1
2	Food Purchase		159,333		159,333	0	159,333	(1,303)	158,030		2
3	Housekeeping	155,887	9,933	0	165,820		165,820	(247)	165,573		3
4	Laundry	17,186	8,794	0	25,980	0	25,980	(480)	25,500		4
5	Heat and Other Utilities			114,784	114,784		114,784	0	114,784		5
6	Maintenance	50,372	21,116	24,918	96,406		96,406	6,134	102,540		6
7	Other (specify):*			17,387	17,387		17,387	0	17,387		7
8	TOTAL General Services	390,157	218,781	168,012	776,950	0	776,950	3,879	780,829		8
	B. Health Care and Programs										
9	Medical Director	0		22,500	22,500		22,500	0	22,500		9
10	Nursing and Medical Records	1,464,725	136,621	70,413	1,671,759		1,671,759	(43,694)	1,628,065		10
10a	Therapy	0		100	100		100	0	100		10a
11	Activities	100,913	7,218	17,600	125,731		125,731	(501)	125,230		11
12	Social Services	40,875		2,900	43,775		43,775	0	43,775		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			2,416	2,416		2,416	0	2,416		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,606,513	143,839	115,929	1,866,281	0	1,866,281	(44,195)	1,822,086		16
	C. General Administration										
17	Administrative	80,152		407,689	487,841		487,841	(407,227)	80,614		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			355,362	355,362		355,362	(165,412)	189,950		19
20	Dues, Fees, Subscriptions & Promotions			130,495	130,495		130,495	(112,461)	18,034		20
21	Clerical & General Office Expenses	125,356	30,723	60,148	216,227		216,227	146,980	363,207		21
22	Employee Benefits & Payroll Taxes			371,395	371,395	0	371,395	0	371,395		22
23	Inservice Training & Education			7,196	7,196		7,196	0	7,196		23
24	Travel and Seminar			650	650		650	6,722	7,372		24
25	Other Admin. Staff Transportation			17,282	17,282		17,282	0	17,282		25
26	Insurance-Prop.Liab.Malpractice			124,159	124,159		124,159	3,559	127,718		26
27	Other (specify):*			35,976	35,976		35,976	(35,976)	0		27
28	TOTAL General Administration	205,508	30,723	1,510,352	1,746,583	0	1,746,583	(563,815)	1,182,768		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,202,178	393,343	1,794,293	4,389,814	0	4,389,814	(604,131)	3,785,683		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	10,923
	REPAIRS & MAINTENANCE	0
		0
		10,923
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	0
	ELECTRICITY	80,830
	WATER	33,954
	CABLE TV - LOBBY	0
		0
		114,784
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,041
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,763
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,357
	FIRE SERVICE	8,757
		0
		0
		0
		0
		24,918
7	OTHER	
	SCAVENGER	16,508
	SECURITY SERVICE	879
		0
		0
		17,387
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	22,500
		22,500

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	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
		70,413
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	100
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		100
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	14,700
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,900
		0
		17,600
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,900
		0
		2,900
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	2,416
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	407,689
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	36,117
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	319,245
		0
		355,362
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	84,326
	EMPLOYEE WANT ADS XIX F	271
	CONTRIBUTIONS VI 20 XIX F	1,956
	DUES & SUBSCRIPTIONS XIX F	13,950
	LICENSES & PERMITS XIX F	1,491
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	23,440
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,661
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	400
	PATIENT BACKGROUND CHECKS XIX F	1,000
		130,495
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	720
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,650
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	79
	TELEPHONE	53,763
	MESSENGER SERVICE	3,936
		0
		60,148

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	166,102
	UNEMPLOYMENT COMPENSATION XIX D	24,351
	WORKERS COMPENSATION INSURANC XIX D	58,397
	HOSPITALIZATION INSURANCE XIX D	108,540
	EMPLOYEE BENEFITS - OTHER XIX D	9,125
	EMPLOYEE PHYSICAL EXAMS XIX D	1,363
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	3,517
	CHICAGO HEAD TAX XIX D	0
		0
		371,395
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	7,196
		7,196
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	650
		650
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	17,282
		17,282
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	124,159
		124,159
27	OTHER	
	BAD DEBTS VI 24	35,976
		35,976

GRAND TOTAL COLUMN 3 OTHER

1,794,293

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

TOTAL FOOD PURCHASE	159,333	PATIENT MEALS	118362
LESS SALES TAX	(1,303)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	158,030	TOTAL MEALS/YEAR	118362
TOTAL PATIENT CENSUS	39,454	NET FOOD	158030
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	118362

TOTAL PATIENT MEALS	118362	COST PER MEAL	1.34
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

MAPLE RIDGE CARE CENTER

#0042366

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			69,075	69,075		69,075	166,862	235,937			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			262,100	262,100		262,100	232,413	494,513			32
33	Real Estate Taxes			39,457	39,457		39,457	0	39,457			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(515,641)	24,359			34
35	Rent-Equipment & Vehicles			31,926	31,926		31,926	6,870	38,796			35
36	Other (specify):* STORAGE			3,454	3,454		3,454	17,969	21,423			36
37	TOTAL Ownership			946,012	946,012	0	946,012	(91,527)	854,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		212,897	210,798	423,695		423,695	0	423,695			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			68,940	68,940		68,940	0	68,940			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	212,897	279,738	492,635	0	492,635	0	492,635			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,202,178	606,240	3,020,043	5,828,461	0	5,828,461	(695,658)	5,132,803			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	(23,267)	30		9
10	Interest and Other Investment Income	(36,653)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,303)	2		13
14	Non-Care Related Interest	0	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	(1,650)	21		18
19	Entertainment	0	20		19
20	Contributions	(5,617)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,976)	27		24
25	Fund Raising, Advertising and Promotional	(84,326)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(23,440)	20		28
29	Other-Attach Schedule	(9,052)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (221,284)		\$ 0	30

BHF 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)	(474,374)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (474,374)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (695,658)		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 CENTER

ID# 0042366

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 5,920	6	1
2	VACATION ACCRUAL	(225)	1	2
3	VACATION ACCRUAL	(247)	3	3
4	VACATION ACCRUAL	(480)	4	4
5	VACATION ACCRUAL	214	6	5
6	VACATION ACCRUAL	(2,163)	10	6
7	VACATION ACCRUAL	(501)	11	7
8	VACATION ACCRUAL	(11)	17	8
9	VACATION ACCRUAL	(1,756)	21	9
10	MEDICARE CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING CONSULTANT	(3,500)	19	11
12	MEDICARE A BILLING	(403)	19	12
13	MARKETING CONSULTANT	(3,900)	19	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	(9,052)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE RIDGE CARE CENTER# 0042366

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	(225)	0	0	0	0	0	0	0	0	0	0	(225)	1
2	Food Purchase	(1,303)	0	0	0	0	0	0	0	0	0	0	(1,303)	2
3	Housekeeping	(247)	0	0	0	0	0	0	0	0	0	0	(247)	3
4	Laundry	(480)	0	0	0	0	0	0	0	0	0	0	(480)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	6,134	0	0	0	0	0	0	0	0	0	0	6,134	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	3,879	0	0	0	0	0	0	0	0	0	0	3,879	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	(2,163)	0	0	(41,531)	0	0	0	0	0	0	0	(43,694)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(501)	0	0	0	0	0	0	0	0	0	0	(501)	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	(2,664)	0	0	(41,531)	0	0	0	0	0	0	0	(44,195)	16
	C. General Administration													
17	Administrative	(11)	0	(305,767)	0	473	(101,922)	0	0	0	0	0	(407,227)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,803)	0	58,005	470	(214,084)	0	0	0	0	0	0	(165,412)	19
20	Fees, Subscriptions & Promotions	(113,383)	0	125	426	371	0	0	0	0	0	0	(112,461)	20
21	Clerical & General Office Expenses	(3,406)	0	20,391	2,781	127,214	0	0	0	0	0	0	146,980	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	1,520	2,576	2,626	0	0	0	0	0	0	6,722	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	0	1,270	1,300	989	0	0	0	0	0	0	3,559	26
27	Other (specify):*	(35,976)	0	0	0	0	0	0	0	0	0	0	(35,976)	27
28	TOTAL General Administration	(162,579)	0	(224,456)	7,553	(82,411)	(101,922)	0	0	0	0	0	(563,815)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(161,364)	0	(224,456)	(33,978)	(82,411)	(101,922)	0	0	0	0	0	(604,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE RIDGE CARE CENTER# 0042366

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	(23,267)	187,566	237	138	2,188	0	0	0	0	0	0	166,862	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(36,653)	269,066	0	0	0	0	0	0	0	0	0	232,413	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	1,143	23,216	0	0	0	0	0	0	(515,641)	34
35	Rent-Equipment & Vehicles	0	0	3,662	1,587	1,621	0	0	0	0	0	0	6,870	35
36	Other (specify):*	0	17,969	0	0	0	0	0	0	0	0	0	17,969	36
37	TOTAL Ownership	(59,920)	(65,399)	3,899	2,868	27,025	0	0	0	0	0	0	(91,527)	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)	(221,284)	(65,399)	(220,557)	(31,110)	(55,386)	(101,922)	0	0	0	0	0	(695,658)	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:	
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	34 RENT	\$ 540,000	MAPLE RIDGE LLC		\$	(540,000)	1
2	V	36 MORTGAGE INSURANCE		" "		17,969	17,969	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		119,198	119,198	3
4	V	30 DEPRECIATION - EQPT		" "		68,368	68,368	4
5	V	32 AMORTIZATION - MTG COST		" "		5,061	5,061	5
6	V	32 INTEREST - MORTGAGE		" "		239,442	239,442	6
7	V	32 INTEREST - OTHER		" "		24,563	24,563	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 540,000			\$ 474,601	\$ * (65,399)	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	\$	YORK MANAGEMENT ASSOCIATES, LLC		\$ 58,005	\$ 58,005
16	V	20 DUES & SUBSCRIPTIONS		"		125	125
17	V	21 CLERICAL		"		20,391	20,391
18	V	24 TRAVEL		"		1,520	1,520
19	V	26 INSURANCE		"		1,270	1,270
20	V	35 RENT - EQPT & VEH.		"		3,662	3,662
21	V	17 ADMINISTRATIVE	305,767	"			(305,767)
22	V	30 DEPRECIATION				237	237
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		\$ 305,767			\$ 85,210	\$ * (220,557)

* 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		\$ 27,682	\$ (41,531)
16	V	19 PROFESSIONAL FEES		"		470	470
17	V	20 DUES & SUBSCRIPTIONS		"		426	426
18	V	21 CLERICAL		"		2,781	2,781
19	V	24 TRAVEL		"		2,576	2,576
20	V	26 INSURANCE		"		1,300	1,300
21	V	30 DEPRECIATION		"		138	138
22	V	34 RENT		"		1,143	1,143
23	V	35 RENT - EQPT & VEH		"		1,587	1,587
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			\$ 38,103	\$ * (31,110)

* 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		\$ 1,839	\$ (214,084)
16	V	20 DUES & SUBSCRIPTIONS		"		371	371
17	V	21 CLERICAL		"		127,214	127,214
18	V	24 TRAVEL		"		2,626	2,626
19	V	26 INSURANCE		"		989	989
20	V	30 DEPRECIATION		"		2,188	2,188
21	V	34 RENT		"		23,216	23,216
22	V	35 RENT - EQPT & VEH		"		1,621	1,621
23	V	17 ADMINISTRATIVE		"		473	473
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			\$ 160,537	\$ * (55,386)

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

Facility Name & ID Number MAPLE RIDGE CARE CENTER

0042366

Report 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	17 ADMINISTRATIVE	\$ 101,922	CHESTERFIELD, LLC		\$	\$ (101,922)
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		\$ 101,922			\$ 0	\$ * (101,922)

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

Facility Name & ID Number MAPLE RIDGE CARE CENTER # 0042366 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 RIDGE CARE CENTER

0042366

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 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	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	176,808	4	\$ 259,936	\$ 39,454	\$ 58,005	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	176,808	4	560	39,454	125	2
3	21	CLERICAL	PATIENT DAYS	176,808	4	3,152	39,454	704	3
4	24	TRAVEL	PATIENT DAYS	176,808	4	6,813	39,454	1,520	4
5	26	INSURANCE	PATIENT DAYS	176,808	4	5,690	39,454	1,270	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	176,808	4	16,410	39,454	3,662	6
7	30	DEPRECIATION	PATIENT DAYS	176,808	4	1,064	39,454	237	7
8	21	CLERICAL	DIRECT COST	1	1	19,687	19,687	1	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					\$ 313,312	\$ 19,687	\$ 85,210	25

Facility Name & ID Number MAPLE RIDGE CARE CENTER

0042366 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 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 COST	1	\$ 27,682	\$ 27,682	1	\$ 27,682	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	6,221	39,454	470	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	5,639	39,454	426	3
4	21	CLERICAL	PATIENT DAYS	522,604	11	36,838	39,454	2,781	4
5	24	TRAVEL	PATIENT DAYS	522,604	11	34,123	39,454	2,576	5
6	26	INSURANCE	PATIENT DAYS	522,604	11	17,224	39,454	1,300	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	11	1,834	39,454	138	7
8	34	RENT	PATIENT DAYS	522,604	11	15,145	39,454	1,143	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	522,604	11	21,023	39,454	1,587	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				\$ 165,729	\$ 27,682		\$ 38,103	25

Facility Name & ID Number MAPLE RIDGE CARE CENTER

0042366 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	\$ 39,454	\$ 1,839	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	4,910	39,454	371	2
3	21	CLERICAL	PATIENT DAYS	522,604	11	162,920	39,454	12,301	3
4	24	TRAVEL	PATIENT DAYS	522,604	11	34,777	39,454	2,626	4
5	26	INSURANCE	PATIENT DAYS	522,604	11	13,097	39,454	989	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	11	28,982	39,454	2,188	6
7	34	RENT	PATIENT DAYS	522,604	11	307,494	39,454	23,216	7
8	35	RENT - EQPT & VEH.	PATIENT DAYS	522,604	11	21,468	39,454	1,621	8
9	21	CLERICAL	DIRECT COST	1	1	114,913	114,913	1	9
10	17	ADMINISTRATIVE	DIRECT COST	1	1	473	1	473	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					\$ 713,386	\$ 114,913	\$ 160,537	25

Facility Name & ID Number

MAPLE RIDGE CARE CENTER

0042366

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	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	3,578,013	07/2037	6.6600	239,442	2						
3	LOAN COST		X	LOAN COST - AMORT 35 YEARS			119,751	96,021			5,061	3						
4												4						
5												5						
	Working Capital																	
6	CHESTERFIELD, LLC	X		WORKING CAPITAL	DEMAND	12/04	150,000	828,064	DEMAND	VARIES	38,929	6						
7	LANDMARK	X		WORKING CAPITAL	DEMAND	DEMAND	450,000	3,771,864	DEMAND	VARIES	247,036	7						
8	LETTER OF CREDIT FEE		X								698	8						
9	TOTAL Facility Related						\$ 4,435,101	\$ 8,273,962			\$ 531,166	9						
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 4,435,101	\$ 8,273,962			\$ 531,166	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 2005 report.		\$	36,324	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.)		\$	37,681	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,357	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	38,100	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.		\$	39,457	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	29,586	8
	2002	33,607	9
	2003	34,100	10
	2004	35,932	11
	2005	37,681	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 RIDGE CARE CENTER 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 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>08-029-019-00</u>	<u>NURSING HOME</u>	\$ <u>37,680.94</u>	\$ <u>37,680.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>37,680.94</u>	\$ <u>37,680.94</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 RIDGE CARE CENTER

0042366

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,852 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).

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>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 CENTER

0042366

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	120	1996		\$ 2,496,225	\$ 90,772	27.5	\$ 90,772	\$	\$ 926,630	4
5		1997		15,792	574	27.5	574		5,430	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		2,561	10
11	FENCE		1997	4,300	156	27.5	156		1,477	11
12	WALLCOVERING/TILE WORK		1997	11,399	415	27.5	415		3,923	12
13	INSTALLATION OF WALLCOVERING		1997	10,590	385	27.5	385		3,642	13
14	FLOOR TILES/INSTALLATION		1997	1,160	42	27.5	42		398	14
15	OUTDOOR SIGN		1997	10,880	396	27.5	396		3,744	15
16	WALLCOVERING/TILE WORK/INSTALLATION		1998	30,545	1,111	27.5	1,111		9,396	16
17	WALLCOVERING/DRYWALL/WINDOW FRAMES		1999	31,471	1,144	27.5	1,144		8,534	17
18	OUTDOOR SIGN		1999	4,190	152	27.5	152		1,135	18
19	PAVEMENT		1999	6,230	227	27.5	227		1,691	19
20	REMODELING, OFFICE, ROOF CURB, DOORS		2000	22,801	829	27.5	829		5,354	20
21	WALLCOVERING, PAINTING		2000	3,683	134	27.5	134		865	21
22	PAINT & PREP ALL DOORS, BATHROOMS, KITCHEN, STORE RM		2001	13,835	503	27.5	503		2,746	22
23	EDGE VENEER COUNTER TOPS		2001	1,028	37	27.5	37		203	23
24	REMOVE & INSTALL I05 SYSTEM RUBBER ROOFING		2001	9,880	359	27.5	359		1,960	24
25	REPLACE DAMAGED SOFFIT & FASCIA ON THE OUTSIDE		2001	2,486	90	27.5	90		492	25
26	TEAR OUT AND REBUILD SECTION OF ASPHALT PRKG LOT		2002	4,477	163	27.5	163		727	26
27	EXTEND 2 WALLS TO ROOF DECK & DRYWALL COVER		2002	4,034	147	27.5	147		655	27
28	NURSING STATION - CALL LIGHT SYSTEM		2002	28,723	1,044	27.5	1,044		4,655	28
29	RUN ELECTRICITY OUT TO THE PAVILLION		2002	1,396	51	27.5	51		228	29
30	RAISE FLOORS IN 4 ROOMS, ALONG OUTSIDE WALL		2003	3,570	130	27.5	130		417	30
31	REPAIR ASPHALT - ENTIRE PARKING LOT		2003	8,545	311	27.5	311		998	31
32	INSTALL ROOF TOP UNIT		2003	6,918	252	27.5	252		808	32
33	ADDITION OF 6 BEDS		2006	325,154	11,331	27.5	11,331		11,331	33
34	PREP, PAINT & INSTALL WALL PAPER-RMS 4,47,50,55,57,12,36		2006	24,250	4,850	5	4,850		4,850	34
35	REPAIR ASPHALT - PAVEMENT, DRIVE LAND & PARKING		2006	6,275	314	15	314		314	35
36	PREP, PAINT & INSTALL WALL PAPER-RMS 4,47,50,55,57,12,36		2006	2,295	459	5	459		459	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 REMOVE & INSTALL ALL DINING ROOM WINDOWS	2006	\$ 12,790	\$ 252	27.5	\$ 252	\$	\$ 252	37
38 PREP, PAINT & WALL PAPER RMS - 4,47,50,55, & DOORS	2006	2,110	422	5	422		422	38
39 VINYL BLINDS FOR 8 WINDOWS	2006	715	14	27.5	14		14	39
40 PREP, PAINT & WALL PAPER RMS - 4,47,50,55, & DOORS	2006	1,151	230	5	230		230	40
41	2006	8,156	1,631	5	1,631		1,631	41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,124,495	\$ 119,198		\$ 119,198	\$ 0	\$ 1,008,172	70

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

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

0042366

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	\$ 479,932	\$ 60,355	\$ 43,628	\$ (16,727)	3-10 YRS	\$ 208,211	71
72	Current Year Purchases	43,597	8,720	2,180	(6,540)	3-10 YRS	2,180	72
73	Fully Depreciated Assets	26,857			0		26,857	73
74	RELATED PARTIES	683,675	70,931	70,931	0	10 YRS	678,419	74
75	TOTALS	\$ 1,234,061	\$ 140,006	\$ 116,739	\$ (23,267)		\$ 915,667	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)	\$ 4,506,908	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 259,204	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 235,937	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,267)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,923,839	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A RELATED PARTY**

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 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: \$ **29,718** 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	FACILITY USE	99 DODGE DURANGO	\$ 295.13	\$ 2,208	17
18					18
19					19
20					20
21	TOTAL		\$ 295.13	\$ 2,208	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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		Contract	Total
		1 Drop-outs	2 Completed		
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	\$		\$ 99,311	\$		\$ 99,311	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			43,593			43,593	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			62,255			62,255	4
5	Physician Care	39-3	visits			2,849			2,849	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				139,192		139,192	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					73,705		73,705	13
14	TOTAL			\$		\$ 210,798	\$ 212,897		\$ 423,695	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 CENTER

0042366

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	\$ (262,735)	\$ 196,661	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,239,023	1,239,023	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,258	93,594	6
7	Other Prepaid Expenses	21,091	21,091	7
8	Accounts Receivable (owners or related parties)	620,192	172,370	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		1,220,592	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,647,829	\$ 2,943,331	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	874,838	1,158,353	11
12	Long-Term Investments	1,081	1,081	12
13	Land		585,600	13
14	Buildings, at Historical Cost		3,318,321	14
15	Leasehold Improvements, at Historical Cost		692,549	15
16	Equipment, at Historical Cost	531,845	1,395,520	16
17	Accumulated Depreciation (book methods)	(416,100)	(2,619,058)	17
18	Deferred Charges	1,197	97,218	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)	\$ 992,861	\$ 4,629,584	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,640,690	\$ 7,572,915	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 456,559	\$ 480,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,895	53,895	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,900	82,900	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,169	10,169	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,100	32
33	Accrued Interest Payable	63,886	32,029	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	104,550	104,550	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 771,959	\$ 801,902	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,069,409	1,683,739	39
40	Mortgage Payable		5,770,988	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)	\$ 4,069,409	\$ 7,454,727	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,841,368	\$ 8,256,629	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,200,678)	\$ (683,714)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,640,690	\$ 7,572,915	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,398,062)	1
2	Restatements (describe):		2
3	ROUNDING ADJ	(5)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,398,067)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(802,611)	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)	\$ (802,611)	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)	\$ (2,200,678)	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	\$ 4,989,197	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,989,197	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36,653	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,653	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)	\$ 5,025,850	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	776,950	31
32	Health Care	1,866,281	32
33	General Administration	1,746,583	33
	B. Capital Expense		
34	Ownership	946,012	34
	C. Ancillary Expense		
35	Special Cost Centers	423,695	35
36	Provider Participation Fee	68,940	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,828,461	40
41	Income before Income Taxes (line 30 minus line 40)**	(802,611)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (802,611)	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 CENTER

0042366

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	663	\$ 22,329	\$ 28.66	1
2	Assistant Director of Nursing	1,648	46,791	25.74	2
3	Registered Nurses	4,001	101,881	23.71	3
4	Licensed Practical Nurses	30,301	606,207	18.32	4
5	CNAs & Orderlies	59,119	652,896	10.05	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,946	25,907	11.98	9
10	Activity Assistants	6,357	75,006	10.96	10
11	Social Service Workers	1,925	40,875	19.59	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	7,869	79,799	9.19	14
15	Cook Helpers/Assistants	11,356	86,913	7.08	15
16	Dishwashers				16
17	Maintenance Workers	2,606	50,372	17.39	17
18	Housekeepers	16,756	155,887	8.64	18
19	Laundry	2,406	17,186	6.74	19
20	Administrator	2,037	80,152	34.58	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	6,456	125,356	17.83	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	2,312	34,621	13.59	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	157,758	\$ 2,202,178 *	\$ 12.78	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	167	\$ 10,923	1-3	35
36	Medical Director	144	22,500	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	458	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	1	100	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	44	2,900	11-3	44
45	Social Service Consultant	44	2,900	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	954	\$ 109,736		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-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								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	06/2003	\$ 7,519	3	\$ 1,253	\$ 2,506	\$ 2,506	\$ 1,254	\$	\$	\$	\$													
2	PAINT/DECORATING	06/2004	6,565	3		1,094	2,188	2,188	1,095																
3	PAINT/DECORATING	06/2005	7,434	3			1,239	2,478	2,478	1,239															
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19																									
20	TOTALS		\$ 21,518		\$ 1,253	\$ 3,600	\$ 5,933	\$ 5,920	\$ 3,573	\$ 1,239	\$	\$													

Facility Name & ID Number MAPLE RIDGE CARE CENTER

0042366

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. HEALTHCARE ASSOC. - \$6180; ILL COUNCIL ON LTC - \$4193
- (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. \$ 5,200 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. \$ 68,940
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