

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	2,660	3,057	3,619	9,336	8
9	SNF/PED					9
10	ICF	9,577	11,003		20,580	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,237	14,060	3,619	29,916	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.30%

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 3,232

Medicare Intermediary WPS (WISCONSIN PHYSICIANS SERVICES)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	190,856	21,113	8,120	220,089		220,089	1,482	221,571		1
2	Food Purchase		139,807		139,807		139,807	(1,558)	138,249		2
3	Housekeeping	46,278	19,295		65,573		65,573	395	65,968		3
4	Laundry	53,405	16,316	1,990	71,711		71,711	780	72,491		4
5	Heat and Other Utilities			111,506	111,506		111,506		111,506		5
6	Maintenance	65,300	16,948	55,501	137,749		137,749	635	138,384		6
7	Other (specify):*			5,467	5,467		5,467		5,467		7
8	TOTAL General Services	355,839	213,479	182,584	751,902		751,902	1,734	753,636		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,471,336	78,478	59,274	1,609,088		1,609,088	(15,480)	1,593,608		10
10a	Therapy	71,647			71,647		71,647		71,647		10a
11	Activities	104,588	6,568	3,313	114,469		114,469	739	115,208		11
12	Social Services			5,213	5,213		5,213		5,213		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,647,571	85,046	72,600	1,805,217		1,805,217	(14,741)	1,790,476		16
	C. General Administration										
17	Administrative	72,674		389,263	461,937		461,937	(391,936)	70,001		17
18	Directors Fees										18
19	Professional Services			218,762	218,762		218,762	(102,654)	116,108		19
20	Dues, Fees, Subscriptions & Promotions			102,736	102,736		102,736	(64,742)	37,994		20
21	Clerical & General Office Expenses	78,629	31,533	17,632	127,794		127,794	94,905	222,699		21
22	Employee Benefits & Payroll Taxes			331,576	331,576		331,576		331,576		22
23	Inservice Training & Education			3,966	3,966		3,966		3,966		23
24	Travel and Seminar			845	845		845	6,145	6,990		24
25	Other Admin. Staff Transportation			3,062	3,062		3,062		3,062		25
26	Insurance-Prop.Liab.Malpractice			145,212	145,212		145,212	3,691	148,903		26
27	Other (specify):*			24,000	24,000		24,000	(24,000)			27
28	TOTAL General Administration	151,303	31,533	1,237,054	1,419,890		1,419,890	(478,591)	941,299		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,154,713	330,058	1,492,238	3,977,009		3,977,009	(491,598)	3,485,411		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	812
		0
		8,120
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,990
		0
		1,990
5	HEAT & OTHER UTILITIES	
	GAS HEAT	64,865
	ELECTRICITY	39,782
	WATER	6,859
	CABLE TV - LOBBY	0
		0
		111,506
6	MAINTENANCE	
	GROUNDS MAINTENANCE	15,353
	PAINTING & DECORATING	47
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	34,673
	ELEVATOR MAINTENANCE & REPAIR	1,108
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,833
	FIRE SERVICE	2,487
		0
		0
		0
		0
		55,501
7	OTHER	
	SCAVENGER	5,221
	SECURITY SERVICE	246
		0
		0
		5,467
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	844
	PHARMACY CONSULTANT XVIII B 39-2	2,736
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	55,694
		0
		0
		59,274
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	2,181
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,132
		0
		3,313
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	5,213
	SOCIAL WORKER XVIII B 45-2	0
		0
		5,213
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	389,263
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	30,931
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	187,831
		0
		218,762
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	35,268
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	23,717
	EMPLOYEE WANT ADS XIX F	29,676
	CONTRIBUTIONS VI 20 XIX F	380
	DUES & SUBSCRIPTIONS XIX F	5,629
	LICENSES & PERMITS XIX F	959
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,721
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,221
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	750
	PATIENT BACKGROUND CHECKS XIX F	415
		102,736
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,474
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,518
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,191
	MESSENGER SERVICE	2,449
		0
		17,632

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	157,802
	UNEMPLOYMENT COMPENSATION XIX D	19,131
	WORKERS COMPENSATION INSURANC XIX D	39,932
	HOSPITALIZATION INSURANCE XIX D	103,822
	EMPLOYEE BENEFITS - OTHER XIX D	4,507
	EMPLOYEE PHYSICAL EXAMS XIX D	1,320
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,062
	CHICAGO HEAD TAX XIX D	0
		0
		331,576
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,966
		3,966
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	845
		845
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,062
		3,062
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	145,212
		145,212
27	OTHER	
	BAD DEBTS VI 24	24,000
		24,000

GRAND TOTAL COLUMN 3 OTHER

1,492,238

**MAPLE CREST CARE CENTRE
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	139,807
LESS SALES TAX	<u>(1,558)</u>
NET FOOD	138,249

TOTAL PATIENT CENSUS	29,916
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	89,748

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	89,748
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	89,748

NET FOOD	138,249
DIVIDE TOTAL MEALS/YEAR	<u>89,748</u>

COST PER MEAL	1.54
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number

MAPLE CREST CARE CENTRE

#0044172

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			92,113	92,113		92,113	(17,766)	74,347			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,013	73,013		73,013	(11,458)	61,555			32
33	Real Estate Taxes			62,560	62,560		62,560		62,560			33
34	Rent-Facility & Grounds			87,458	87,458		87,458	22,543	110,001			34
35	Rent-Equipment & Vehicles			12,674	12,674		12,674	4,706	17,380			35
36	Other (specify):*											36
37	TOTAL Ownership			327,818	327,818		327,818	(1,975)	325,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,353	262,393	364,746		364,746		364,746			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		102,353	309,478	411,831		411,831		411,831			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,154,713	432,411	2,129,534	4,716,658		4,716,658	(493,573)	4,223,085			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	BHF 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	(20,313)	30		9
10	Interest and Other Investment Income	(11,458)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,558)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,518)	21		18
19	Entertainment	(35,268)	20		19
20	Contributions	(1,601)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,838)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(23,717)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,721)	20		28
29	Other-Attach Schedule	(3,151)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,143)		\$	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)	(363,430)	PG 6-6C	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (363,430)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (493,573)		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 CREST CARE CENTRE

ID# 0044172

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	VACATION ACCRUAL	1,482	1	2
3	VACATION ACCRUAL	395	3	3
4	VACATION ACCRUAL	780	4	4
5	VACATION ACCRUAL	635	6	5
6	VACATION ACCRUAL	(292)	10	6
7	VACATION ACCRUAL	739	11	7
8	VACATION ACCRUAL	(2,673)	17	8
9	VACATION ACCRUAL	(152)	21	9
10				10
11	PINNACLE CONSULTING (ADVERTISING)	(4,065)	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	(3,151)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**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	1,482	0	0	0	0	0	0	0	0	0	0	1,482	1
2	Food Purchase	(1,558)	0	0	0	0	0	0	0	0	0	0	(1,558)	2
3	Housekeeping	395	0	0	0	0	0	0	0	0	0	0	395	3
4	Laundry	780	0	0	0	0	0	0	0	0	0	0	780	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	635	0	0	0	0	0	0	0	0	0	0	635	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,734	0	0	0	0	0	0	0	0	0	0	1,734	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	(292)	0	(15,188)	0	0	0	0	0	0	0	0	(15,480)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	739	0	0	0	0	0	0	0	0	0	0	739	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	447	0	(15,188)	0	0	0	0	0	0	0	0	(14,741)	16
	C. General Administration													
17	Administrative	(2,673)	(291,947)	0	0	(97,316)	0	0	0	0	0	0	(391,936)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,903)	25,648	437	(121,836)	0	0	0	0	0	0	0	(102,654)	19
20	Fees, Subscriptions & Promotions	(65,307)	236	65	264	0	0	0	0	0	0	0	(64,742)	20
21	Clerical & General Office Expenses	(1,670)	5,351	733	90,491	0	0	0	0	0	0	0	94,905	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	2,440	1,754	1,951	0	0	0	0	0	0	0	6,145	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	997	1,157	1,537	0	0	0	0	0	0	0	3,691	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	TOTAL General Administration	(100,553)	(257,275)	4,146	(27,593)	(97,316)	0	0	0	0	0	0	(478,591)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(98,372)	(257,275)	(11,042)	(27,593)	(97,316)	0	0	0	0	0	0	(491,598)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(20,313)	247	111	2,189	0	0	0	0	0	0	0	(17,766)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,458)	0	0	0	0	0	0	0	0	0	0	(11,458)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	893	21,650	0	0	0	0	0	0	0	22,543	34
35	Rent-Equipment & Vehicles	0	1,590	1,803	1,313	0	0	0	0	0	0	0	4,706	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,771)	1,837	2,807	25,152	0	0	0	0	0	0	0	(1,975)	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)	(130,143)	(255,438)	(8,235)	(2,441)	(97,316)	0	0	0	0	0	0	(493,573)	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		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	\$ 291,947	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		\$	(291,947)	1
2	V	19 PROFESSIONAL FEES		"		25,648	25,648	2
3	V	20 DUES & SUBSCRIPTIONS		"		236	236	3
4	V	21 CLERICAL		"		5,351	5,351	4
5	V	24 TRAVEL		"		2,440	2,440	5
6	V	26 INSURANCE		"		997	997	6
7	V	35 RENT - EQPT & VEHICLES		"		1,590	1,590	7
8	V	30 DEPRECIATION		"		247	247	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 291,947			\$ 36,509	\$ * (255,438)	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		\$ 33,261	\$ (15,188)
16	V	19 PROFESSIONAL FEES				437	437
17	V	20 DUES & SUBSCRIPTIONS				65	65
18	V	21 CLERICAL				733	733
19	V	24 TRAVEL				1,754	1,754
20	V	26 INSURANCE				1,157	1,157
21	V	30 DEPRECIATION				111	111
22	V	34 RENT				893	893
23	V	35 RENT - EQPT & VEH				1,803	1,803
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			\$ 40,214	\$ * (8,235)

* 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	\$ 124,120	THE KENSINGTON GROUP, LLC		\$ 2,284	\$ (121,836)
16	V	20 DUES & SUBSCRIPTIONS		"		264	264
17	V	21 CLERICAL		"		90,491	90,491
18	V	24 TRAVEL		"		1,951	1,951
19	V	26 INSURANCE		"		1,537	1,537
20	V	30 DEPRECIATION		"		2,189	2,189
21	V	34 RENT		"		21,650	21,650
22	V	35 RENT - EQPT & VEH		"		1,313	1,313
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		\$ 124,120			\$ 121,679	\$ * (2,441)

* 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	\$ 97,316	CHESTERFIELD, LLC		\$	\$	(97,316)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 97,316			\$	0	\$ * (97,316)	39

* 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: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007

Ending: 2/31/2007

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 WITTINGHAM MANAGEMENT ASSO.
 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	368,840	7	\$ 316,248	\$ 29,916	\$ 25,648	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	368,840	7	2,914	29,916	236	2
3	21	CLERICAL	PATIENT DAYS	368,840	7	65,982	29,916	5,351	3
4	24	TRAVEL	PATIENT DAYS	368,840	7	30,090	29,916	2,440	4
5	26	INSURANCE	PATIENT DAYS	368,840	7	12,294	29,916	997	5
6	35	RENT - EQPT & VEH.	PATIENT DAYS	368,840	7	19,611	29,916	1,590	6
7									7
8	30	DEPRECIATION	PATIENT DAYS	368,840	7	3,051	29,916	247	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					\$ 450,190	\$	\$ 36,509	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 CARLYLE NURSING ASSOC. LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, ILL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 33,261	\$ 33,261	1	\$ 33,261	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	8,078	29,916	437	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	1,197	29,916	65	3
4	21	CLERICAL	PATIENT DAYS	553,355	11	13,541	29,916	733	4
5	24	TRAVEL	PATIENT DAYS	553,355	11	32,426	29,916	1,754	5
6	26	INSURANCE	PATIENT DAYS	553,355	11	21,389	29,916	1,157	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	11	2,056	29,916	111	7
8	34	RENT	PATIENT DAYS	553,355	11	16,500	29,916	893	8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	553,355	11	33,327	29,916	1,803	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				\$ 161,775	\$ 33,261		\$ 40,214	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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	553,355	11	\$ 42,255	\$ 29,916	\$ 2,284	1	
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	29,916	264	2	
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	29,916	11,022	3	
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	29,916	1,951	4	
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	29,916	1,537	5	
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	29,916	2,189	6	
7	34	RENT	PATIENT DAYS	553,355	11	400,473	29,916	21,650	7	
8	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	11	24,297	29,916	1,313	8	
9									9	
10	21	CLERICAL	DIRECT HOURS	1	1	79,469	79,469	1	79,469	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					\$ 860,290	\$ 79,469	\$ 121,679	25	

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MEMBER LOANS	X		WORKING CAPITAL	DEMAND	VARIES	150,000	291,901	DEMAND		20,995	6						
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	721,000	595,928	DEMAND	VARIES	52,018	7						
8												8						
9	TOTAL Facility Related						\$ 871,000	\$ 887,829			\$ 73,013	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 871,000	\$ 887,829			\$ 73,013	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 2006 report.		\$	31,848	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.)		\$	46,948	2
3. Under or (over) accrual (line 2 minus line 1).		\$	15,100	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	47,460	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.		\$	62,560	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	30,960	8
	2003	29,862	9
	2004	30,884	10
	2005	31,506	11
	2006	46,948	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 2006 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>46,947.92</u>	\$ <u>46,947.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>46,947.92</u>	\$ <u>46,947.92</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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:

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

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		7			17,944	9
10		STEEL DOORS		1999	2,337	85	27.5	85		735	10
11		SIGN, SIGN FOOTINGS AND BRICKS		1999	4,652	169	27.5	169		1,373	11
12		REMODEL - DINING & REC. ROOMS, OFFICES, HALLS		1999	73,951	2,689	27.5	2,689		22,079	12
13		CONDENSING UNIT FOR WALK IN FREEZER		2000	3,695	134	27.5	134		955	13
14		WATER SOFTENER UNIT		2000	10,120	368	27.5	368		2,622	14
15		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS		2001	11,239	409	27.5	409		2,846	15
16		TWO HOT WATER HEATERS		2001	13,065	475	27.5	475		3,305	16
17		REMOVAL OF WATER TANKS & PIPING		2001	7,650	278	27.5	278		1,911	17
18		REPAIRS TO GRAVEL ROOF		2001	2,875	105	27.5	105		695	18
19		BALCK TOP PARKING LOT		2001	1,270	46	27.5	46		305	19
20		AIRCONDITIONING - REPAIRS & INSTALLATION - DINING RM.		2001	7,430	270	27.5	270		1,766	20
21		ASBESTOS ABATEMENT/FLOOR RENOVATION		2001	1,400	51	27.5	51		332	21
22		REPLACE WATER COIL - FOOD STORAGE AREA		2001	7,500	273	27.5	273		1,740	22
23		INSTALL CONTROL DAMPER IN BATHING AREA		2001	1,795	65	27.5	65		404	23
24		BOILER ROOM EXHAUST FAN		2001	1,980	72	27.5	72		447	24
25		REPLACE DAMPER ON GENERATOR		2001	1,260	46	27.5	46		282	25
26		ADDITION OF 6 BEDS - GENERAL CONST./WINDOWS/PAINTING		2001	103,815	3,775	27.5	3,775		23,122	26
27		EXHAUST FANS FOR KITCHEN & DISHWASHING AREA		2001	5,894	214	27.5	214		1,311	27
28		AIR CONDITIONING CONDENSING UNIT		2002	8,557	311	27.5	311		1,762	28
29		ROOF REPAIR OVER LAUNDRY RM, RMS 212 & 114 FOYER		2002	9,800	356	27.5	356		1,958	29
30		ROOF REPAIRS		2002	2,030	74	27.5	74		382	30
31		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS		2003	5,607	204	27.5	204		918	31
32		CONSTRUCTION OF 2 BED ADDITION - FROM 84 BEDS TO 86		2003	76,097	2,767	27.5	2,767		12,452	32
33		ROOF REPAIRS IN THE VALLEY, LAUNDRY RM & BEAUTY SALC		2003	4,627	168	27.5	168		756	33
34		NEW A/C UNIT IN DINING ROOM		2003	16,997	618	27.5	618		2,781	34
35		25 TON BRYANT CONDENSING UNIT - OFFICE AREA		2004	10,620	386	27.5	386		1,384	35
36		ELECTRICAL REPAIRS ON CONDUITS IN KITCHEN FLOOR		2004	4,407	160	27.5	160		547	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

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 174	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		1,244	39
40	KITCHEN TILES - BEHIND DISHWASHER AND SINKS	2005	1,500	55	27.5	55		165	40
41	WALLCOVERINGS, DRAPES, CUBICLE CURTAINS - RES. R	2006	41,904	13,409	5	8,381	(5,028)	16,762	41
42	CORRIDOR CEILING UPGRADES	2006	23,625	859	27.5	859		1,468	42
43	REMOVE & INSTALL TILES & HAND RAILS - 100, 200 WING	2006	45,000	1,637	27.5	1,637		2,523	43
44	REPAIR DOORS, INSTALL CARPET & WALL PAPER - 100 W	2006	20,000	6,400	5	4,000	(2,400)	8,000	44
45	INSTALL 5 EXTERIOR WALL PACKS FLOOD LAMPS	2006	1,714	62	27.5	62		96	45
46	INSTALL 460' DECO SHIELD FOR NEW PIPING	2006	4,388	160	27.5	160		246	46
47	INSTALL SEWAGE PUMP	2006	7,391	269	27.5	269		392	47
48	REPLACED FIRE ALARM PANEL	2006	4,730	172	27.5	172		222	48
49	NEW NURSES WORK STATIONS & SECURITY CAMERAS	2006	11,486	418	27.5	418		540	49
50	VCT FLOORING FOR NURSES STATIONS & REC. ROOM	2006	2,533	92	27.5	92		111	50
51	REPLACE 175FT OF 4" SEWER BETWEEN EAST & WEST								51
52	MANHOLE	2007	4,260	142	27.5	142		142	52
53	BLINDS, WALLCOVERINGS, AWNING FOR SHOWCASE	2007	4,215	115	27.5	115		115	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)		\$ 602,760	\$ 38,773		\$ 31,345	\$ (7,428)	\$ 139,314	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 359,818	\$ 17,891	\$ 35,982	\$ 18,091	3-10 YRS	\$ 180,621	71
72	Current Year Purchases	89,457	35,449	4,473	(30,976)	3-10 YRS	4,473	72
73	Fully Depreciated Assets	15,390				3-10 YRS	15,390	73
74	RELATED PARTY		2,547	2,547				74
75	TOTALS	\$ 464,665	\$ 55,887	\$ 43,002	\$ (12,885)		\$ 200,484	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,067,425	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,347	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,313)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 339,798	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:	78	02/01/99	\$ 87,458	30		3
4	Additions	12/11/2001	6				4
5		05/13/2003	2				5
6							6
7	TOTAL		86	\$ 87,458			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: \$ 10,439 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	ADMINISTRATIVE	2003 HONDA CIVIC	\$ 229.00	\$ 2,235	17
18					18
19					19
20					20
21	TOTAL		\$ 229.00	\$ 2,235	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. 12/31/2008 \$ 90,956

13. 12/31/2009 \$ 94,595

14. 12/31/2010 \$ 98,379

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

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	\$		\$ 131,366	\$		\$ 131,366	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,505			8,505	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			122,522			122,522	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				89,173		89,173	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					13,180		13,180	13
14	TOTAL			\$		\$ 262,393	\$ 102,353		\$ 364,746	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 162,177	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 63,954)	1,170,584		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,161		6
7	Other Prepaid Expenses	18,855		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,386,777	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	242,550		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	602,759		15
16	Equipment, at Historical Cost	464,665		16
17	Accumulated Depreciation (book methods)	(493,253)		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)	\$ 816,721	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,203,498	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 225,358	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	132,700		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,187		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,680		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,460		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>	92,610		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 625,995	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	887,829		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)	\$ 887,829	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,513,824	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 689,674	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,203,498	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 645,446	1
2	Restatements (describe):		2
3	1065 REFUND	682	3
4	ROUNDING ADJ.	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 646,129	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	193,545	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	(150,000)	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)	\$ 43,545	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 689,674	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	\$ 4,898,598	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,898,598	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	147	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)	\$ 147	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,458	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,458	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,910,203	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	751,902	31
32	Health Care	1,805,217	32
33	General Administration	1,419,890	33
	B. Capital Expense		
34	Ownership	327,818	34
	C. Ancillary Expense		
35	Special Cost Centers	364,746	35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,716,658	40
41	Income before Income Taxes (line 30 minus line 40)**	193,545	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 193,545	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: 01/01/2007

Ending: 12/31/2007

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,885	2,094	\$ 77,668	\$ 37.09	1
2	Assistant Director of Nursing	1,879	2,154	65,179	30.26	2
3	Registered Nurses	9,420	10,540	277,079	26.29	3
4	Licensed Practical Nurses	12,747	13,955	315,215	22.59	4
5	CNAs & Orderlies	52,914	58,069	637,087	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,549	4,092	71,647	17.51	8
9	Activity Director	1,908	2,137	34,307	16.05	9
10	Activity Assistants	6,669	7,333	70,281	9.58	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,296	8,363	108,359	12.96	14
15	Cook Helpers/Assistants	9,657	10,334	82,497	7.98	15
16	Dishwashers					16
17	Maintenance Workers	3,879	4,350	65,300	15.01	17
18	Housekeepers	5,741	6,274	46,278	7.38	18
19	Laundry	6,454	7,099	53,405	7.52	19
20	Administrator	1,998	2,086	72,674	34.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,188	4,648	78,629	16.92	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	3,845	4,280	99,108	23.16	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,029	147,808	\$ 2,154,713 *	\$ 14.58	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	844	10-3	37
38	Nurse Consultant	546	55,694	10-3	38
39	Pharmacist Consultant	144	2,736	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	17	1,132	11-3	44
45	Social Service Consultant	77	5,213	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	980	\$ 77,727		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

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. \$ 1,470 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 \$5,000, 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