



Facility Name & ID Number MAPLE RIDGE CARE CENTRE

# 0042366 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	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,240	790	5,674	10,704	8
9	SNF/PED					9
10	ICF	21,993	4,101		26,094	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,233	4,891	5,674	36,798	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.01%

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 11/01/1996

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 3,995

Medicare Intermediary WPS (WISCONSIN PHYSICIANS SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL  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 RIDGE CARE CENTRE # 0042366 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
	<b>A. General Services</b>										
1	Dietary	166,601	28,223	12,385	207,209		207,209	613	207,822		1
2	Food Purchase		158,839		158,839		158,839	(2,508)	156,331		2
3	Housekeeping	142,492	12,468		154,960		154,960	(938)	154,022		3
4	Laundry	38,276	8,964		47,240		47,240	(90)	47,150		4
5	Heat and Other Utilities			173,686	173,686		173,686		173,686		5
6	Maintenance	52,010	21,891	25,944	99,845		99,845	2,363	102,208		6
7	Other (specify):*			19,881	19,881		19,881		19,881		7
8	<b>TOTAL General Services</b>	399,379	230,385	231,896	861,660		861,660	(560)	861,100		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			45,500	45,500		45,500		45,500		9
10	Nursing and Medical Records	1,974,707	171,684	75,127	2,221,518		2,221,518	(41,077)	2,180,441		10
10a	Therapy			35	35		35		35		10a
11	Activities	121,231	8,004	15,353	144,588		144,588	172	144,760		11
12	Social Services			2,656	2,656		2,656		2,656		12
13	CNA Training										13
14	Program Transportation			2,931	2,931		2,931		2,931		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,095,938	179,688	141,602	2,417,228		2,417,228	(40,905)	2,376,323		16
	<b>C. General Administration</b>										
17	Administrative	83,233		408,564	491,797		491,797	(408,565)	83,232		17
18	Directors Fees										18
19	Professional Services			354,238	354,238		354,238	(224,319)	129,919		19
20	Dues, Fees, Subscriptions & Promotions			178,464	178,464		178,464	(145,444)	33,020		20
21	Clerical & General Office Expenses	130,684	25,115	62,065	217,864		217,864	113,926	331,790		21
22	Employee Benefits & Payroll Taxes			439,682	439,682		439,682		439,682		22
23	Inservice Training & Education			22,215	22,215		22,215		22,215		23
24	Travel and Seminar			2,058	2,058		2,058	8,281	10,339		24
25	Other Admin. Staff Transportation			13,462	13,462		13,462		13,462		25
26	Insurance-Prop.Liab.Malpractice			83,643	83,643		83,643	4,602	88,245		26
27	Other (specify):*			53,577	53,577		53,577	(53,577)			27
28	<b>TOTAL General Administration</b>	213,917	25,115	1,617,968	1,857,000		1,857,000	(705,096)	1,151,904		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,709,234	435,188	1,991,466	5,135,888		5,135,888	(746,561)	4,389,327		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	12,385
	REPAIRS & MAINTENANCE	0
		0
		12,385
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	0
	ELECTRICITY	136,138
	WATER	37,548
	CABLE TV - LOBBY	0
		0
		173,686
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,845
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	7,165
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,588
	FIRE SERVICE	7,346
		0
		0
		0
		0
		25,944
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	19,881
	SECURITY SERVICE	0
		0
		0
		19,881
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	45,500
		45,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	4,714
	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
		75,127
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	35
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		35
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	12,697
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,656
		0
		15,353
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,656
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,656
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	2,931
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	408,564
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	26,442
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	327,796
		0
		354,238
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	47,305
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	68,696
	EMPLOYEE WANT ADS XIX F	13,083
	CONTRIBUTIONS VI 20 XIX F	1,299
	DUES & SUBSCRIPTIONS XIX F	14,471
	LICENSES & PERMITS XIX F	2,736
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	27,096
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,603
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	765
	PATIENT BACKGROUND CHECKS XIX F	1,410
		178,464
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	287
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,859
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	40
	TELEPHONE	54,856
	MESSENGER SERVICE	4,023
		0
		62,065

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	203,953
	UNEMPLOYMENT COMPENSATION XIX D	27,565
	WORKERS COMPENSATION INSURANC XIX D	54,688
	HOSPITALIZATION INSURANCE XIX D	136,727
	EMPLOYEE BENEFITS - OTHER XIX D	6,081
	EMPLOYEE PHYSICAL EXAMS XIX D	3,730
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	6,938
	CHICAGO HEAD TAX XIX D	0
		0
		439,682
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	22,215
		22,215
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	2,058
		2,058
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	13,462
		13,462
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	83,643
		83,643
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	53,577
		53,577

GRAND TOTAL COLUMN 3 OTHER

1,991,466

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

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

TOTAL FOOD PURCHASE	158,839
LESS SALES TAX	<u>(2,508)</u>
NET FOOD	156,331

TOTAL PATIENT CENSUS	36,798
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	110,394

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

PATIENT MEALS	110,394
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	110,394

NET FOOD	156,331
DIVIDE TOTAL MEALS/YEAR	<u>110,394</u>

COST PER MEAL	1.42
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE

#0042366

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	
	<b>D. Ownership</b>											
30	Depreciation			61,285	61,285		61,285	118,879	180,164			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			329,517	329,517		329,517	225,598	555,115			32
33	Real Estate Taxes			43,233	43,233		43,233		43,233			33
34	Rent-Facility & Grounds			540,000	540,000		540,000	(512,272)	27,728			34
35	Rent-Equipment & Vehicles			51,875	51,875		51,875	6,855	58,730			35
36	Other (specify):* <b>STORAGE/MTG INS.</b>			3,906	3,906		3,906	17,789	21,695			36
37	<b>TOTAL Ownership</b>			1,029,816	1,029,816		1,029,816	(143,151)	886,665			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		455,376	235,192	690,568		690,568		690,568			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		455,376	304,177	759,553		759,553		759,553			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,709,234	890,564	3,325,459	6,925,257		6,925,257	(889,712)	6,035,545			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,877)	30		9
10	Interest and Other Investment Income	(40,350)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,508)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,859)	21		18
19	Entertainment	(47,305)	20		19
20	Contributions	(2,902)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,577)	27		24
25	Fund Raising, Advertising and Promotional	(68,696)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(27,096)	20		28
29	Other-Attach Schedule	(11,044)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (267,214)		\$	30

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

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(622,498)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (622,498)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (889,712)		37

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

## MAPLE RIDGE CARE CENTRE

ID# 0042366

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 3,573	6	1
2	VACATION ACCRUAL	613	1	2
3	VACATION ACCRUAL	(938)	3	3
4	VACATION ACCRUAL	(90)	4	4
5	VACATION ACCRUAL	(1,210)	6	5
6	VACATION ACCRUAL	(5,879)	10	6
7	VACATION ACCRUAL	172	11	7
8	VACATION ACCRUAL	(1)	17	8
9	VACATION ACCRUAL	(553)	21	9
10	MEDICARE CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING CONSULTANT	(300)	19	11
12	MEDICARE A BILLING	(366)	19	12
13	MARKETING CONSULTANT	(4,065)	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	<b>Total</b>	(11,044)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE RIDGE CARE CENTRE# 0042366 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	613	0	0	0	0	0	0	0	0	0	0	613	1
2	Food Purchase	(2,508)	0	0	0	0	0	0	0	0	0	0	(2,508)	2
3	Housekeeping	(938)	0	0	0	0	0	0	0	0	0	0	(938)	3
4	Laundry	(90)	0	0	0	0	0	0	0	0	0	0	(90)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,363	0	0	0	0	0	0	0	0	0	0	2,363	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(560)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(560)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(5,879)	0	0	(35,198)	0	0	0	0	0	0	0	(41,077)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	172	0	0	0	0	0	0	0	0	0	0	172	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	<b>TOTAL Health Care and Programs</b>	<b>(5,707)</b>	<b>0</b>	<b>0</b>	<b>(35,198)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40,905)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(1)	0	(306,423)	0	0	(102,141)	0	0	0	0	0	(408,565)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,731)	5,930	(5,850)	537	(218,205)	0	0	0	0	0	0	(224,319)	19
20	Fees, Subscriptions & Promotions	(145,999)	0	150	80	325	0	0	0	0	0	0	(145,444)	20
21	Clerical & General Office Expenses	(3,412)	0	970	900	115,468	0	0	0	0	0	0	113,926	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	3,725	2,156	2,400	0	0	0	0	0	0	8,281	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	1,289	1,422	1,891	0	0	0	0	0	0	4,602	26
27	Other (specify):*	(53,577)	0	0	0	0	0	0	0	0	0	0	(53,577)	27
28	<b>TOTAL General Administration</b>	<b>(209,720)</b>	<b>5,930</b>	<b>(306,139)</b>	<b>5,095</b>	<b>(98,121)</b>	<b>(102,141)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(705,096)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(215,987)</b>	<b>5,930</b>	<b>(306,139)</b>	<b>(30,103)</b>	<b>(98,121)</b>	<b>(102,141)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(746,561)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE RIDGE CARE CENTRE# 0042366

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	(10,877)	126,786	140	137	2,693	0	0	0	0	0	0	118,879	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,350)	265,948	0	0	0	0	0	0	0	0	0	225,598	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	1,097	26,631	0	0	0	0	0	0	(512,272)	34
35	Rent-Equipment & Vehicles	0	0	3,023	2,216	1,616	0	0	0	0	0	0	6,855	35
36	Other (specify):*	0	17,789	0	0	0	0	0	0	0	0	0	17,789	36
37	<b>TOTAL Ownership</b>	<b>(51,227)</b>	<b>(129,477)</b>	<b>3,163</b>	<b>3,450</b>	<b>30,940</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(143,151)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(267,214)</b>	<b>(123,547)</b>	<b>(302,976)</b>	<b>(26,653)</b>	<b>(67,181)</b>	<b>(102,141)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(889,712)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		MAPLE RIDGE, LLC	MORTON GROVE	REAL ESTATE
				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	34 RENT	\$ 540,000	MAPLE RIDGE LLC		\$	(540,000)	1
2	V	36 MORTGAGE INSURANCE		" "		17,789	17,789	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		125,918	125,918	3
4	V	30 DEPRECIATION - EQPT		" "		868	868	4
5	V	32 AMORTIZATION - MTG COST		" "		3,148	3,148	5
6	V	32 INTEREST - MORTGAGE		" "		237,045	237,045	6
7	V	32 INTEREST - OTHER		" "		25,755	25,755	7
8	V	19 ACCOUNTING FEES		" "		5,806	5,806	8
9	V	19 DATA PROCESSING		" "		124	124	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 540,000			\$ 416,453	\$ * (123,547)	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	\$ 33,845	YORK MANAGEMENT ASSOCIATES, LLC		\$ 27,995	\$ (5,850)
16	V	20 DUES & SUBSCRIPTIONS		"		150	150
17	V	21 CLERICAL		"		970	970
18	V	24 TRAVEL		"		3,725	3,725
19	V	26 INSURANCE		"		1,289	1,289
20	V	35 RENT -EQPT & VEH		"		3,023	3,023
21	V	17 ADMINISTRATIVE	306,423	"			(306,423)
22	V	30 DEPRECIATION		"		140	140
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		\$ 340,268			\$ 37,292	\$ * (302,976)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 69,213	CARLYLE NURSING ASSOCIATES, LLC		\$ 34,015	\$ (35,198)
16	V	19 PROFESSIONAL FEES		"		537	537
17	V	20 DUES & SUBSCRIPTIONS		"		80	80
18	V	21 CLERICAL		"		900	900
19	V	24 TRAVEL		"		2,156	2,156
20	V	26 INSURANCE		"		1,422	1,422
21	V	30 DEPRECIATION		"		137	137
22	V	34 RENT		"		1,097	1,097
23	V	35 RENT - EQPT & VEH		"		2,216	2,216
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			\$ 42,560	\$ * (26,653)

\* 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	\$ 221,015	THE KENSINGTON GROUP, LLC		\$ 2,810	\$ (218,205)
16	V	20 DUES & SUBSCRIPTIONS		" "		325	325
17	V	21 CLERICAL		" "		115,468	115,468
18	V	24 TRAVEL		" "		2,400	2,400
19	V	26 INSURANCE		" "		1,891	1,891
20	V	30 DEPRECIATION		" "		2,693	2,693
21	V	34 RENT		" "		26,631	26,631
22	V	35 RENT - EQPT & VEH		" "		1,616	1,616
23	V	17 ADMINISTRATIVE		" "			
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		\$ 221,015			\$ 153,834	\$ * (67,181)

\* 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	\$ 102,141	CHESTERFIELD, LLC		\$	\$	(102,141)	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		\$ 102,141			\$	0	\$ * (102,141)	39

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

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2007 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 RIDGE CARE CENTRE

# 0042366 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 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

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	184,515	4	\$ 140,375	\$ 36,798	\$ 27,995	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	184,515	4	750	36,798	150	2
3	21	CLERICAL	PATIENT DAYS	184,515	4	4,865	36,798	970	3
4	24	TRAVEL	PATIENT DAYS	184,515	4	18,678	36,798	3,725	4
5	26	INSURANCE	PATIENT DAYS	184,515	4	6,463	36,798	1,289	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	184,515	4	15,160	36,798	3,023	6
7	30	DEPRECIATION	PATIENT DAYS	184,515	4	701	36,798	140	7
8							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					\$ 186,992	\$	\$ 37,292	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

# 0042366 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 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	\$ 34,015	\$ 34,015	1	\$ 34,015	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	8,078		36,798	537	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	1,197		36,798	80	3
4	21	CLERICAL	PATIENT DAYS	553,355	13,541		36,798	900	4
5	24	TRAVEL	PATIENT DAYS	553,355	32,426		36,798	2,156	5
6	26	INSURANCE	PATIENT DAYS	553,355	21,389		36,798	1,422	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	2,056		36,798	137	7
8	34	RENT	PATIENT DAYS	553,355	16,500		36,798	1,097	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	33,327		36,798	2,216	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				\$ 162,529	\$ 34,015		\$ 42,560	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

# 0042366 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 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	\$ 36,798	\$ 2,810	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	36,798	325	2
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	36,798	13,558	3
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	36,798	2,400	4
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	36,798	1,891	5
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	36,798	2,693	6
7	34	RENT	PATIENT DAYS	553,355	11	400,473	36,798	26,631	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	11	24,297	36,798	1,616	8
9	21	CLERICAL	DIRECT COST	1	1	101,910	101,910	1	101,910
10							1		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					\$ 882,731	\$ 101,910	\$ 153,834	25

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

# 0042366

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	RELATED PARTY - MAPLE RIDGE, LLC																			
2	GMAC MORTGAGE COST	X		MORTGAGE	07/2002	3,715,350	3,540,916	07/2037	6.6600	237,045										
3	LOAN COST	X		LOAN COST -AMORT 35 YEARS		119,751	92,873			3,148										
4																				
5																				
<b>Working Capital</b>																				
6	CHESTERFIELD, LLC	X		WORKING CAPITAL	DEMAND	12/04	150,000	1,629,285	DEMAND	VARIES	78,642									
7	LANDMARK	X		WORKING CAPITAL	DEMAND	DEMAND	450,000	4,337,595	DEMAND	VARIES	275,932									
8	LETTER OF CREDIT FEE		X							698										
9	TOTAL Facility Related					\$ 4,435,101	\$ 9,600,669			\$ 595,465										
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC		X	LATE FEES																
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$ 4,435,101	\$ 9,600,669			\$ 595,465										

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.		\$	<b>38,100</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>40,433</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,333</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>40,900</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>43,233</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>33,607</b>	8
	2003	<b>34,100</b>	9
	2004	<b>35,932</b>	10
	2005	<b>37,681</b>	11
	2006	<b>40,433</b>	12

<b>FOR BHF USE ONLY</b>			
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 RIDGE CARE CENTRE COUNTY LOGAN

FACILITY IDPH LICENSE NUMBER 0042366

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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>08-029-019-00</u>	<u>NURSING HOME</u>	\$ <u>40,433.28</u>	\$ <u>40,433.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>40,433.28</u>	\$ <u>40,433.28</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 RIDGE CARE CENTRE

# 0042366

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>170,750</u>	<u>1996</u>	<u>\$ 148,352</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>170,750</b>		<b>\$ 148,352</b>	<b>3</b>

Facility Name &amp; ID Number MAPLE RIDGE CARE CENTRE

# 0042366

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	120	1996		\$ 2,496,225	\$ 90,772	27.5	\$ 90,772	\$	\$ 1,017,402	4
5		1997		15,792	574	27.5	574		6,004	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	RELATED PARTY - MAPLERIDGE LLC									9
10	DINING ROOM REMODELING		1997	7,441	271	27.5	271		2,832	10
11	FENCE		1997	4,300	156	27.5	156		1,633	11
12	WALLCOVERING/TILE WORK		1997	11,399	415	27.5	415		4,338	12
13	INSTALLATION OF WALLCOVERING		1997	10,590	385	27.5	385		4,027	13
14	FLOOR TILES/ INSTALLATION		1997	1,160	42	27.5	42		440	14
15	OUTDOOR SIGN		1997	10,880	396	27.5	396		4,140	15
16	WALLCOVERING/TILE WORK/INSTALLATION		1998	30,545	1,111	27.5	1,111		10,507	16
17	WALLCOVERING/DRYWALL/WINDOW FRAMES		1999	31,471	1,144	27.5	1,144		9,678	17
18	OUTDOOR SIGN		1999	4,190	152	27.5	152		1,287	18
19	PAVEMENT		1999	6,230	227	27.5	227		1,918	19
20	REMODELING, OFFICE, ROOF CURB, DOORS		2000	22,801	829	27.5	829		6,183	20
21	WALLCOVERING, PAINTING		2000	3,683	134	27.5	134		999	21
22	PAINT & PREP ALL DOORS, BATHROOMS, KITCHEN STORE RM		2001	13,835	503	27.5	503		3,249	22
23	EDGE VENEER COUNTER TOPS		2001	1,028	37	27.5	37		240	23
24	REMOVE & INSTALL I05 SYSTEM RUBBER ROOFING		2001	9,880	359	27.5	359		2,319	24
25	REPLACE DAMAGED SOFFIT & FASCIA ON THE OUTSIDE		2001	2,486	90	27.5	90		582	25
26	TEAR OUT AND REBUILD SECTION OF ASPHALT PRKG LOT		2002	4,477	163	27.5	163		890	26
27	EXTEND 2 WALLS TO ROOF DECK & DRYWALL COVER		2002	4,034	147	27.5	147		802	27
28	NURSING STATION - CALL LIGHT SYSTEM		2002	28,723	1,044	27.5	1,044		5,699	28
29	RUN ELECTRICITY OUT TO THE PAVILLION		2002	1,396	51	27.5	51		279	29
30	RAISE FLOORS IN 4 ROOMS, ALONG OUTSIDE WALL		2003	3,570	130	27.5	130		547	30
31	REPAIR ASPHALT - ENTIRE PARKING LOT		2003	8,545	311	27.5	311		1,309	31
32	INSTALL ROOF TOP UNIT		2003	6,918	252	27.5	252		1,060	32
33	ADDITION OF 6 BEDS		2006	325,154	11,824	27.5	11,824		23,155	33
34	PREP. PAINT & INSTALL WALL PAPER - RMS 4,47,50,55,57,12,36		2006	24,250	7,760	5	4,850	(2,910)	9,700	34
35	REPAIR ASPHALT - PAVEMENT, DRIVE LAND & PARKING		2006	6,275	596	15	418	(178)	732	35
36	PREP, PAINT & INSTALL WALL PAPER-RMS 4,47,50,55,57,12		2006	2,295	734	5	459	(275)	918	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	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 & INSTALL ALL DINING ROOM WINDOWS	2006	\$ 12,790	\$ 465	27.5	\$ 252	\$ (213)	\$ 504	37
38	PREP, PAINT & WALL PAPER RMS - 4,47,50,55 & DOORS	2006	2,110	675	5	422	(253)	844	38
39	VINYL BLINDS FOR 8 WINDOWS	2006	715	26	27.5	26		40	39
40	PREP, PAINT & WALL PAPER RMS - 4,47,50,55 & DOORS	2006	1,151	368	5	230	(138)	460	40
41	PREP, PAINT & WALL PAPER RMS, DOORS,FRAMES,CEILI	2006	8,156	2,610	5	1,631	(979)	3,262	41
42	INSTALL EPDM RUBBER ROOF SYSTEM	2007	8,908	297	27.5	297		297	42
43	DESIGN EMERGENCY POWER DISTN FOR VENTILATORS	2007	1,800	60	27.5	60		60	43
44	VALANCES, RODS, BLINDS & BORDERS	2007	3,177	635	5	635		635	44
45	FIRE CAULK WALLS	2007	1,200	240	5	240		240	45
46	2 METAL RAILINGS ON CONCRETE RAMP	2007	1,740	32	27.5	32		32	46
47	PATCH & PAINT - ROOMS 40, 48,3,21,6 ACTIVITY ROOM	2007	24,235	4,847	5	4,847		4,847	47
48									48
49			ADJ TO SL	(4,946)			4,946		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)		\$ 3,165,555	\$ 125,918		\$ 125,918	\$	\$ 1,134,090	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	\$ 514,666	\$ 48,513	\$ 47,215	\$ (1,298)		\$ 248,743	71
72	Current Year Purchases	63,859	12,772	3,193	(9,579)		3,193	72
73	Fully Depreciated Assets	17,180					17,180	73
74	<b>RELATED PARTIES</b>	8,675	3,838	3,838			4,402	74
75	<b>TOTALS</b>	\$ 604,380	\$ 65,123	\$ 54,246	\$ (10,877)		\$ 273,518	75

**D. Vehicle Depreciation (See instructions.)\***

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

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,918,287	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,041	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,164	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,877)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,407,608	85

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

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

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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: \$ 51,875 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. \_\_\_\_\_/2008 \$ \_\_\_\_\_

13. \_\_\_\_\_/2009 \$ \_\_\_\_\_

14. \_\_\_\_\_/2010 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training 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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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	\$		\$ 95,582	\$		\$ 95,582	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			29,220			29,220	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			104,684			104,684	4
5	Physician Care	39-3	visits			2,916			2,916	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				168,853		168,853	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): <b>RENTAL</b>	39-2					286,523		286,523	13
14	<b>TOTAL</b>			\$		\$ 235,192	\$ 455,376		\$ 690,568	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 &amp; ID Number MAPLE RIDGE CARE CENTRE

# 0042366

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 139,149	\$ 328,825	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 34,339 )	1,261,969	1,261,969	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,434	84,488	6
7	Other Prepaid Expenses	26,379	26,379	7
8	Accounts Receivable (owners or related parties)	558,443	327,889	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		1,240,549	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,016,374	\$ 3,270,099	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	912,751	1,064,790	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		743,880	15
16	Equipment, at Historical Cost	595,705	1,459,380	16
17	Accumulated Depreciation (book methods)	(477,385)	(2,847,532)	17
18	Deferred Charges		92,873	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,032,152	\$ 4,418,393	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,048,526	\$ 7,688,492	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 787,575	\$ 812,575	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,526	55,526	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,830	137,830	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,763	16,763	31
32	Accrued Real Estate Taxes(Sch.IX-B)		40,900	32
33	Accrued Interest Payable	82,277	32,686	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DUE TO DPA</u>	10,634	10,634	36
37	<u>MANAGEMENT FEES</u>	225,114	225,114	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,315,719	\$ 1,332,028	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	5,410,606	2,526,501	39
40	Mortgage Payable		5,711,155	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,410,606	\$ 8,237,656	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,726,325	\$ 9,569,684	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,677,799)	\$ (1,881,192)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,048,526	\$ 7,688,492	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,200,678)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>REPLACEMENT TAX REFUND</b>	<b>103</b>	<b>3</b>
<b>4</b>	<b>ROUNDING ADJ.</b>	<b>3</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,200,572)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,477,227)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,477,227)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(3,677,799)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,407,059	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,407,059	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	621	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 621	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	40,350	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 40,350	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,448,030	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	861,660	31
32	Health Care	2,417,228	32
33	General Administration	1,857,000	33
	<b>B. Capital Expense</b>		
34	Ownership	1,029,816	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	690,568	35
36	Provider Participation Fee	68,985	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38	<b>NET VENDING COSTS</b>		38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,925,257	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,477,227)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,477,227)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE

# 0042366

Report Period Beginning: 01/01/2007

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	2,231	2,319	\$ 73,718	\$ 31.79	1
2	Assistant Director of Nursing	1,446	1,519	43,551	28.67	2
3	Registered Nurses	11,590	12,415	297,833	23.99	3
4	Licensed Practical Nurses	36,316	39,353	753,053	19.14	4
5	CNAs & Orderlies	66,827	73,062	776,647	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,862	2,119	26,207	12.37	9
10	Activity Assistants	6,630	7,390	95,024	12.86	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,419	8,055	76,609	9.51	14
15	Cook Helpers/Assistants	10,864	11,941	89,992	7.54	15
16	Dishwashers					16
17	Maintenance Workers	2,396	2,593	52,010	20.06	17
18	Housekeepers	13,232	14,789	142,492	9.63	18
19	Laundry	4,947	5,143	38,276	7.44	19
20	Administrator	2,037	2,294	83,233	36.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,219	6,908	130,684	18.92	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	2,119	2,251	29,905	13.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,135	192,151	\$ 2,709,234 *	\$ 14.10	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	181	\$ 12,385	1-3	35
36	Medical Director	256	45,500	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	440	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	35	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	44	2,656	11-3	44
45	Social Service Consultant	44	2,656	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,062	\$ 133,645		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	12	\$ 518	10-3	50
51	Licensed Practical Nurses	89	4,196	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	101	\$ 4,714		53



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/2004	\$ 6,565	3	\$ 1,094	\$ 2,188	\$ 2,188	\$ 1,095												
2	PAINT/DECORATING	06/2005	7,434	3		1,239	2,478	2,478	1,239											
3																				
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17																				
18																				
19																				
20	<b>TOTALS</b>		\$ 13,999		\$ 1,094	\$ 3,427	\$ 4,666	\$ 3,573	\$ 1,239											

Facility Name &amp; ID Number MAPLE RIDGE CARE CENTRE

# 0042366

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 - \$6156
- (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. \$ 3,907 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. \$ 68,985  
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