

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	31,476	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	31,476	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	1,799	1,548	4,148	7,495	8
9	SNF/PED					9
10	ICF	10,177	8,772	1,776	20,725	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,976	10,320	5,924	28,220	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.66%

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 3,837

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	191,438	9,825	7,997	209,260		209,260	(1,182)	208,078		1
2	Food Purchase		147,714		147,714		147,714	(3,060)	144,654		2
3	Housekeeping	58,279	21,688		79,967		79,967	(642)	79,325		3
4	Laundry	49,882	20,193	3,463	73,538		73,538	157	73,695		4
5	Heat and Other Utilities			121,065	121,065		121,065		121,065		5
6	Maintenance	71,054	42,836	62,227	176,117		176,117	(323)	175,794		6
7	Other (specify):*			6,785	6,785		6,785		6,785		7
8	TOTAL General Services	370,653	242,256	201,537	814,446		814,446	(5,050)	809,396		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,503,544	97,740	131,744	1,733,028		1,733,028	(63,221)	1,669,807		10
10a	Therapy	70,542			70,542		70,542		70,542		10a
11	Activities	118,422	10,010	6,531	134,963		134,963	790	135,753		11
12	Social Services			5,416	5,416		5,416		5,416		12
13	CNA Training										13
14	Program Transportation			83	83		83		83		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,692,508	107,750	148,574	1,948,832		1,948,832	(62,431)	1,886,401		16
	C. General Administration										
17	Administrative	81,177		397,284	478,461		478,461	(401,294)	77,167		17
18	Directors Fees										18
19	Professional Services			199,642	199,642		199,642	(87,704)	111,938		19
20	Dues, Fees, Subscriptions & Promotions			143,347	143,347		143,347	(119,489)	23,858		20
21	Clerical & General Office Expenses	85,646	28,779	19,771	134,196		134,196	94,304	228,500		21
22	Employee Benefits & Payroll Taxes			355,891	355,891		355,891		355,891		22
23	Inservice Training & Education			5,775	5,775		5,775		5,775		23
24	Travel and Seminar							6,703	6,703		24
25	Other Admin. Staff Transportation			3,873	3,873		3,873		3,873		25
26	Insurance-Prop.Liab.Malpractice			142,488	142,488		142,488	9,173	151,661		26
27	Other (specify):*			485,406	485,406		485,406	(485,406)			27
28	TOTAL General Administration	166,823	28,779	1,753,477	1,949,079		1,949,079	(983,713)	965,366		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,229,984	378,785	2,103,588	4,712,357		4,712,357	(1,051,194)	3,661,163		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	7,781
	REPAIRS & MAINTENANCE	216
		0
		7,997
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,463
		0
		3,463
5	HEAT & OTHER UTILITIES	
	GAS HEAT	63,377
	ELECTRICITY	49,362
	WATER	8,326
	CABLE TV - LOBBY	0
		0
		121,065
6	MAINTENANCE	
	GROUNDS MAINTENANCE	19,795
	PAINTING & DECORATING	393
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	30,399
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,558
	FIRE SERVICE	9,082
		0
		0
		0
		0
		62,227
7	OTHER	
	SCAVENGER	6,785
	SECURITY SERVICE	0
		0
		0
		6,785
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	6,281
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	860
	PHARMACY CONSULTANT XVIII B 39-2	4,406
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B 46-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	120,197
		0
		0
		131,744
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY 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	2,952
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,579
		0
		6,531
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	5,416
	SOCIAL WORKER XVIII B 45-2	0
		0
		5,416
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	83
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	397,284
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	26,752
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	172,890
		0
		199,642
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	85,967
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	25,566
	EMPLOYEE WANT ADS XIX F	12,062
	CONTRIBUTIONS VI 20 XIX F	1,160
	DUES & SUBSCRIPTIONS XIX F	7,325
	LICENSES & PERMITS XIX F	2,910
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	3,661
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,660
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	456
	PATIENT BACKGROUND CHECKS XIX F	580
		143,347
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,024
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,011
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,990
	MESSENGER SERVICE	2,746
		0
		19,771

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	167,601
	UNEMPLOYMENT COMPENSATION XIX D	15,886
	WORKERS COMPENSATION INSURANC XIX D	45,170
	HOSPITALIZATION INSURANCE XIX D	112,432
	EMPLOYEE BENEFITS - OTHER XIX D	4,360
	EMPLOYEE PHYSICAL EXAMS XIX D	1,170
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,272
	CHICAGO HEAD TAX XIX D	0
		0
		355,891
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,775
		5,775
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,873
		3,873
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	142,488
		142,488
27	OTHER	
	BAD DEBTS VI 24	485,406
		485,406

GRAND TOTAL COLUMN 3 OTHER

2,103,588

**MAPLE CREST CARE CENTRE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	147,714
LESS SALES TAX	<u>(3,060)</u>
NET FOOD	144,654

TOTAL PATIENT CENSUS	28,220
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	84,660

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	84,660
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	84,660

NET FOOD	144,654
DIVIDE TOTAL MEALS/YEAR	<u>84,660</u>

COST PER MEAL	1.71
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

MAPLE CREST CARE CENTRE

#0044172

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			99,890	99,890		99,890	(18,221)	81,669			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,817	77,817		77,817	(483)	77,334			32
33	Real Estate Taxes			43,408	43,408		43,408		43,408			33
34	Rent-Facility & Grounds			90,956	90,956		90,956	20,814	111,770			34
35	Rent-Equipment & Vehicles			11,719	11,719		11,719	3,653	15,372			35
36	Other (specify):*											36
37	TOTAL Ownership			323,790	323,790		323,790	5,763	329,553			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,416	242,767	387,183		387,183		387,183			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,214	47,214		47,214		47,214			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		144,416	289,981	434,397		434,397		434,397			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,229,984	523,201	2,717,359	5,470,544		5,470,544	(1,045,431)	4,425,113			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	(20,619)	30		9
10	Interest and Other Investment Income	(483)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,060)	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	(2,011)	21		18
19	Entertainment	(85,967)	20		19
20	Contributions	(4,820)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,235)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(485,406)	27		24
25	Fund Raising, Advertising and Promotional	(25,566)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,661)	20		28
29	Other-Attach Schedule	(21,164)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (654,992)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(390,439)	PG 6-6C	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (390,439)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,045,431)		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						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	VACATION ACCRUAL	(1,182)	1	2
3	VACATION ACCRUAL	(642)	3	3
4	VACATION ACCRUAL	157	4	4
5	VACATION ACCRUAL	(323)	6	5
6	VACATION ACCRUAL	(8,151)	10	6
7	VACATION ACCRUAL	790	11	7
8	VACATION ACCRUAL	(4,010)	17	8
9	VACATION ACCRUAL	(775)	21	9
10	PINNACLE CONSULTING (ADVERTISING)	(4,380)	19	10
11	WISCONSIN PHYSICIANS	(648)	19	11
12	AMERICAN HEALTHCARE ASSOC.	(2,000)	19	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	(21,164)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(1,182)	0	0	0	0	0	0	0	0	0	0	(1,182)	1
2	Food Purchase	(3,060)	0	0	0	0	0	0	0	0	0	0	(3,060)	2
3	Housekeeping	(642)	0	0	0	0	0	0	0	0	0	0	(642)	3
4	Laundry	157	0	0	0	0	0	0	0	0	0	0	157	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(323)	0	0	0	0	0	0	0	0	0	0	(323)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,050)	0	0	0	0	0	0	0	0	0	0	(5,050)	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	(8,151)	0	(55,070)	0	0	0	0	0	0	0	0	(63,221)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	790	0	0	0	0	0	0	0	0	0	0	790	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	(7,361)	0	(55,070)	0	0	0	0	0	0	0	0	(62,431)	16
	C. General Administration													
17	Administrative	(4,010)	(297,963)	0	0	(99,321)	0	0	0	0	0	0	(401,294)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,263)	33,997	38	(112,476)	0	0	0	0	0	0	0	(87,704)	19
20	Fees, Subscriptions & Promotions	(120,014)	259	79	187	0	0	0	0	0	0	0	(119,489)	20
21	Clerical & General Office Expenses	(2,786)	7,915	1,391	87,784	0	0	0	0	0	0	0	94,304	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	2,326	2,027	2,350	0	0	0	0	0	0	0	6,703	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	821	1,054	7,298	0	0	0	0	0	0	0	9,173	26
27	Other (specify):*	(485,406)	0	0	0	0	0	0	0	0	0	0	(485,406)	27
28	TOTAL General Administration	(621,479)	(252,645)	4,589	(14,857)	(99,321)	0	0	0	0	0	0	(983,713)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(633,890)	(252,645)	(50,481)	(14,857)	(99,321)	0	0	0	0	0	0	(1,051,194)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(20,619)	238	98	2,062	0	0	0	0	0	0	0	(18,221)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(483)	0	0	0	0	0	0	0	0	0	0	(483)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	1,689	19,125	0	0	0	0	0	0	0	20,814	34
35	Rent-Equipment & Vehicles	0	2,827	0	826	0	0	0	0	0	0	0	3,653	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(21,102)	3,065	1,787	22,013	0	0	0	0	0	0	0	5,763	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)	(654,992)	(249,580)	(48,694)	7,156	(99,321)	0	0	0	0	0	0	(1,045,431)	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	\$ 297,963	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		\$	(297,963)	1
2	V	19 PROFESSIONAL FEES		"		33,997	33,997	2
3	V	20 DUES & SUBSCRIPTIONS		"		259	259	3
4	V	21 CLERICAL		"		7,915	7,915	4
5	V	24 TRAVEL		"		2,326	2,326	5
6	V	26 INSURANCE		"		821	821	6
7	V	35 RENT - EQPT & VEHICLES		"		2,827	2,827	7
8	V	30 DEPRECIATION		"		238	238	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 297,963			\$ 48,383	\$ * (249,580)	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	\$ 120,197	CARLYLE NURSING ASSOCIATES, LLC		\$ 65,127	\$ (55,070)
16	V	19 PROFESSIONAL FEES		"		38	38
17	V	20 DUES & SUBSCRIPTIONS		"		79	79
18	V	21 CLERICAL		"		1,391	1,391
19	V	24 TRAVEL		"		2,027	2,027
20	V	26 INSURANCE		"		1,054	1,054
21	V	30 DEPRECIATION		"		98	98
22	V	34 RENT		"		1,689	1,689
23	V	35 RENT - EQPT & VEH		"			
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		\$ 120,197			\$ 71,503	\$ * (48,694)

* 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	\$ 119,558	THE KENSINGTON GROUP, LLC		\$ 7,082	\$ (112,476)
16	V	20 DUES & SUBSCRIPTIONS		"		187	187
17	V	21 CLERICAL		"		87,784	87,784
18	V	24 TRAVEL		"		2,350	2,350
19	V	26 INSURANCE		"		7,298	7,298
20	V	30 DEPRECIATION		"		2,062	2,062
21	V	34 RENT		"		19,125	19,125
22	V	35 RENT - EQPT & VEH		"		826	826
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		\$ 119,558			\$ 126,714	\$ * 7,156

* 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	\$ 99,321	CHESTERFIELD, LLC		\$	\$	(99,321)	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		\$ 99,321			\$	0	\$ * (99,321)	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:

01/01/2008

Ending:

12/31/2008

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: 01/01/2008

Ending: 2/31/2008

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 ASSOC.
 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	358,373	7	\$ 431,773	\$ 28,220	\$ 33,997	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	358,373	7	3,289	28,220	259	2
3	21	CLERICAL	PATIENT DAYS	358,373	7	100,522	28,220	7,915	3
4	24	TRAVEL	PATIENT DAYS	358,373	7	29,536	28,220	2,326	4
5	26	INSURANCE	PATIENT DAYS	358,373	7	10,431	28,220	821	5
6	35	RENT - EQPT & VEH.	PATIENT DAYS	358,373	7	35,906	28,220	2,827	6
7	30	DEPRECIATION	PATIENT DAYS	358,373	7	3,027	28,220	238	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 614,484	\$	\$ 48,383	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 65,127	\$ 65,127	1	\$ 65,127	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	744		28,220	38	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	1,552		28,220	79	3
4	21	CLERICAL	PATIENT DAYS	554,294	27,317		28,220	1,391	4
5	24	TRAVEL	PATIENT DAYS	554,294	39,814		28,220	2,027	5
6	26	INSURANCE	PATIENT DAYS	554,294	20,700		28,220	1,054	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	1,923		28,220	98	7
8	34	RENT	PATIENT DAYS	554,294			28,220		8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	554,294	33,179		28,220	1,689	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				\$ 190,356	\$ 65,127		\$ 71,503	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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	554,294	11	\$ 139,104	\$ 28,220	\$ 7,082	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	28,220	187	2
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	28,220	9,268	3
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	28,220	2,350	4
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	28,220	7,298	5
6	30	DEPRECIATION	PATIENT DAYS	554,294	11	40,500	28,220	2,062	6
7	34	RENT	PATIENT DAYS	554,294	11	375,668	28,220	19,125	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	16,218	28,220	826	8
9	21	CLERICAL	DIRECT HOURS	1	1	78,516	78,516	1	78,516
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,025,221	\$ 78,516	\$ 126,714	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	314,523	DEMAND	VARIES	22,622	6						
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	721,000	601,123	DEMAND	VARIES	55,195	7						
8												8						
9	TOTAL Facility Related						\$ 871,000	\$ 915,646			\$ 77,817	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	\$ 915,646			\$ 77,817	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 2007 report.		\$	47,460	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.)		\$	45,168	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,292)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	45,700	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.		\$	43,408	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	29,862	8
	2004	30,884	9
	2005	31,506	10
	2006	46,948	11
	2007	45,168	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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 2007 TAX BILL

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>45,168.18</u>	\$ <u>45,168.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>45,168.18</u>	\$ <u>45,168.18</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

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

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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		BLACK 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 FLR.		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:

01/01/2008 Ending: 12/31/2008

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	8,046	5	8,381	335	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 & WALLPAPER - 100 W	2006	20,000	3,840	5	4,000	160	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 175 FT OF 4" SEWER BETWEEN EAST & WEST								51
52	MANHOLE	2007	4,260	155	27.5	155		142	52
53	BLINDS, WALLCOVERINGS, AWNING FOR SHOWCASE	2007	4,215	153	27.5	153		115	53
54	DRYWALL, PAINTING, TILING - THERAPY ROOM, BATHR	2008	15,375	280	27.5	280			54
55	TILES FOR REHAB ROOM	2008	14,203	258	27.5	258			55
56	SHELVING, WALLPAPER, DRYWALL-KITCHEN	2008	12,200	222	27.5	222			56
57	SPRINKLER HEADS	2008	1,938	35	27.5	35			57
58	MIXING VALVES & TILES	2008	2,780	42	27.5	42			58
59	DIFFUSERS	2008	1,624	25	27.5	25			59
60	DRYWALL, PAINTING, TILING - BREAKROOM	2008	21,720	329	27.5	329			60
61	PHONE JACKS & NETWORK CABLES - OFFICES	2008	1,917	29	27.5	29			61
62	SPRINKLER HEADS	2008	595	9	27.5	9			62
63	CERAMIC TILES - BATHROOMS	2008	1,063	13	27.5	13			63
64	WINDOWS FOR THERAPY ROOM	2008	1,482	18	27.5	18			64
65	FLOORING- THERAPY ROOM	2008	4,508	55	27.5	55			65
66	SHOWER ROOMS - TILES & PAINTING	2008	3,373	10	27.5	10			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 685,538	\$ 32,226		\$ 32,721	\$ 495	\$ 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	\$ 449,274	\$ 48,439	\$ 44,927	\$ (3,512)	3-10 YRS	\$ 225,394	71
72	Current Year Purchases	32,806	19,225	1,623	(17,602)	3-10 YRS		72
73	Fully Depreciated Assets	15,390				3-10 YRS		73
74	RELATED PARTY							74
75	TOTALS	\$ 497,470	\$ 67,664	\$ 46,550	\$ (21,114)		\$ 225,394	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)	\$ 1,183,008	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,271	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,619)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 364,708	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	\$ 90,956	30		3
4	Additions	12/11/2001	6					4
5		5/13/2003	2					5
6								6
7	TOTAL		86		\$ 90,956			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: \$ 11,719 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 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. 12/31/2009 \$ 94,595

13. 12/31/2010 \$ 98,379

14. 12/31/2011 \$ _____

* 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	\$		\$ 115,037	\$		\$ 115,037	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,981			14,981	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			111,949			111,949	4
5	Physician Care	39-3	visits			800			800	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				120,892		120,892	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB, X-RAY, I.V. THERAPY Other (specify): RENTALS	39-2					23,524		23,524	13
14	TOTAL			\$		\$ 242,767	\$ 144,416		\$ 387,183	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 47,815	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 493,796)	829,329		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,547		6
7	Other Prepaid Expenses	4,942		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 915,633	\$	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	685,537		15
16	Equipment, at Historical Cost	497,471		16
17	Accumulated Depreciation (book methods)	(593,142)		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)	\$ 832,416	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,748,049	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 454,889	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,386		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,208		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,077		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,700		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	51,894		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 763,154	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	915,646		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)	\$ 915,646	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,678,800	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 69,249	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,748,049	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 689,674	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 689,676	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(555,427)	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	(65,000)	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)	\$ (620,427)	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)	\$ 69,249	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	\$ 4,914,634	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,914,634	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	483	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 483	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)	\$ 4,915,117	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	814,446	31
32	Health Care	1,948,832	32
33	General Administration	1,949,079	33
	B. Capital Expense		
34	Ownership	323,790	34
	C. Ancillary Expense		
35	Special Cost Centers	387,183	35
36	Provider Participation Fee	47,214	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,470,544	40
41	Income before Income Taxes (line 30 minus line 40)**	(555,427)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (555,427)	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: 01/01/2008

Ending: 12/31/2008

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	2,102	2,188	\$ 77,437	\$ 35.39	1
2	Assistant Director of Nursing	1,684	1,754	54,745	31.21	2
3	Registered Nurses	6,267	6,880	191,070	27.77	3
4	Licensed Practical Nurses	17,666	18,857	446,199	23.66	4
5	CNAs & Orderlies	52,636	56,985	630,598	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,420	3,960	70,542	17.81	8
9	Activity Director	3,567	3,930	65,359	16.63	9
10	Activity Assistants	6,027	6,357	53,063	8.35	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,680	4,077	69,071	16.94	13
14	Head Cook	2,909	3,214	29,842	9.29	14
15	Cook Helpers/Assistants	9,990	10,746	92,525	8.61	15
16	Dishwashers					16
17	Maintenance Workers	4,440	4,806	71,054	14.78	17
18	Housekeepers	6,927	7,383	58,279	7.89	18
19	Laundry	5,944	6,396	49,882	7.80	19
20	Administrator	2,025	2,272	81,177	35.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,781	1,934	36,737	19.00	23
24	Clerical	2,816	3,099	48,909	15.78	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	3,938	4,341	103,495	23.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,819	149,179	\$ 2,229,984 *	\$ 14.95	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	159	\$ 7,781	1-3	35
36	Medical Director	24	4,800	9-3	36
37	Medical Records Consultant	16	860	10-3	37
38	Nurse Consultant	687	120,197	10-3	38
39	Pharmacist Consultant	192	4,406	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	49	3,579	11-3	44
45	Social Service Consultant	64	5,416	12-3	45
46	Other(specify)		0		46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,191	\$ 147,039		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 384	10-3	50
51	Licensed Practical Nurses	151	5,897	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	159	\$ 6,281		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MARIE HARTZOG	ADMINISTRATOR		\$ 81,177	Workers' Compensation Insurance	\$ 45,170	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	15,886	Advertising: Employee Recruitment	12,062	
	OTHER ADMIN		0	FICA Taxes	167,601	Health Care Worker Background Check	456	
				Employee Health Insurance	112,432	(Indicate # of checks performed <u>45</u>)		
				Employee Meals	0	Patient Background Checks	58	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,820	
				EMPLOYEE BENEFITS - OTHER	4,360	MARKETING/ADV/PROMO	115,194	
				EMPLOYEE PHYSICAL EXAMS	1,170	LICENSES/DUES/SUBSCRIPTIONS	10,235	
				PENSION/PROFIT SHARING PLANS	9,272	MGMT CO ALLOC	525	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,820)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(85,967)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(25,566)	
						Yellow page advertising	(3,661)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,177	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
WITTINGHAM MNGMT ASSOC. MANAGEMENT FEES			\$ 297,963					
CHESTERFIELD, LLC MANAGEMENT FEES			99,321					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 397,284	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description		Amount		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
		\$			\$	Out-of-State Travel	\$	
						In-State Travel		
						TRAVEL	0	
						RELATED PARTY	6,703	
						Seminar Expense		
							0	
						Entertainment Expense	()	
						(agree to Sch. V, line 24, col. 8)		
SEE SCHEDULE ATTACHED			199,642	TOTAL		TOTAL	\$ 6,703	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 199,642					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAPLE CREST CARE CENTRE

0044172

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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. - \$6384
- (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. \$ 1,403 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. \$ 47,214
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