



Facility Name & ID Number MAPLE CREST CARE CENTRE

# 0044172 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	86	Skilled (SNF)	86	31,390	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,298	1,171	4,465	7,934	8
9	SNF/PED					9
10	ICF	13,022	6,635	1,913	21,570	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,320	7,806	6,378	29,504	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.99%**

**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 02/01/1999

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date 02/01/1999 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 4,303

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: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

MAPLE CREST CARE CENTRE

# 0044172

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	193,748	14,464	11,801	220,013		220,013	1,755	221,768		1
2	Food Purchase		157,792		157,792		157,792	(1,730)	156,062		2
3	Housekeeping	63,910	26,014		89,924		89,924	(45)	89,879		3
4	Laundry	57,394	16,706	2,478	76,578		76,578	581	77,159		4
5	Heat and Other Utilities			108,468	108,468		108,468		108,468		5
6	Maintenance	67,167	23,053	41,645	131,865		131,865	197	132,062		6
7	Other (specify):*			7,456	7,456		7,456		7,456		7
8	<b>TOTAL General Services</b>	382,219	238,029	171,848	792,096		792,096	758	792,854		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,549,165	76,419	54,397	1,679,981		1,679,981	18,250	1,698,231		10
10a	Therapy	111,727			111,727		111,727		111,727		10a
11	Activities	82,864	8,287	4,372	95,523		95,523	1,372	96,895		11
12	Social Services			3,639	3,639		3,639		3,639		12
13	CNA Training										13
14	Program Transportation			878	878		878		878		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,743,756	84,706	74,086	1,902,548		1,902,548	19,622	1,922,170		16
	<b>C. General Administration</b>										
17	Administrative	128,177		221,072	349,249		349,249	(251,117)	98,132		17
18	Directors Fees										18
19	Professional Services			205,406	205,406		205,406	(59,391)	146,015		19
20	Dues, Fees, Subscriptions & Promotions			90,834	90,834		90,834	(70,643)	20,191		20
21	Clerical & General Office Expenses	110,203	29,379	27,726	167,308		167,308	113,393	280,701		21
22	Employee Benefits & Payroll Taxes			403,246	403,246		403,246		403,246		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,594	2,594		2,594	7,180	9,774		24
25	Other Admin. Staff Transportation			7,646	7,646		7,646		7,646		25
26	Insurance-Prop.Liab.Malpractice			135,362	135,362		135,362	3,169	138,531		26
27	Other (specify):*			123,041	123,041		123,041	(123,041)			27
28	<b>TOTAL General Administration</b>	238,380	29,379	1,216,927	1,484,686		1,484,686	(380,450)	1,104,236		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,364,355	352,114	1,462,861	4,179,330		4,179,330	(360,070)	3,819,260		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	7,668
	REPAIRS & MAINTENANCE	4,133
		0
		11,801
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,478
		0
		2,478
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	63,042
	ELECTRICITY	37,007
	WATER	8,419
	CABLE TV - LOBBY	0
		0
		108,468
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	18,930
	PAINTING & DECORATING	277
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,254
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,394
	FIRE SERVICE	3,790
		0
		0
		0
		0
		41,645
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	7,456
	SECURITY SERVICE	0
		0
		0
		7,456
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	10,800
		10,800

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	630
	PHARMACY CONSULTANT XVIII B 39-2	4,509
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	49,258
		0
		0
		54,397
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	3,265
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,107
		0
		4,372
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	3,639
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,639
<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
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	878
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	221,072
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	22,457
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	182,949
		0
		205,406
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	42,087
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	20,297
	EMPLOYEE WANT ADS XIX F	12,058
	CONTRIBUTIONS VI 20 XIX F	1,673
	DUES & SUBSCRIPTIONS XIX F	5,180
	LICENSES & PERMITS XIX F	500
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,204
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,835
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	440
	PATIENT BACKGROUND CHECKS XIX F	1,560
		90,834
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,553
	EQUIPMENT REPAIR & MAINTENANCE	2,454
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	726
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,140
	MESSENGER SERVICE	2,853
		0
		27,726

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	177,620
	UNEMPLOYMENT COMPENSATION XIX D	12,730
	WORKERS COMPENSATION INSURANCE XIX D	48,395
	HOSPITALIZATION INSURANCE XIX D	144,741
	EMPLOYEE BENEFITS - OTHER XIX D	3,660
	EMPLOYEE PHYSICAL EXAMS XIX D	967
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	15,133
	CHICAGO HEAD TAX XIX D	0
		0
		403,246
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	2,594
	TRAVEL XIX G	0
		2,594
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	7,646
		7,646
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	135,362
		135,362
27	<b>OTHER</b>	
	BAD DEBTS VI 24	123,041
		123,041

GRAND TOTAL COLUMN 3 OTHER **1,462,861**

MAPLE CREST CARE CENTRE  
SCHEDULES  
12/31/2009

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

TOTAL FOOD PURCHASE	157,792
LESS SALES TAX	<u>(1,730)</u>
NET FOOD	156,062

TOTAL PATIENT CENSUS	29,504
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	88,512

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

PATIENT MEALS	88,512
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	88,512

NET FOOD	156,062
DIVIDE TOTAL MEALS/YEAR	<u>88,512</u>

COST PER MEAL	1.76
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name &amp; ID Number

MAPLE CREST CARE CENTRE

#0044172

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			107,564	107,564		107,564	(28,018)	79,546			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,376	24,376		24,376	(1,094)	23,282			32
33	Real Estate Taxes			48,031	48,031		48,031		48,031			33
34	Rent-Facility & Grounds			94,595	94,595		94,595	23,919	118,514			34
35	Rent-Equipment & Vehicles			11,129	11,129		11,129	6,298	17,427			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			285,695	285,695		285,695	1,105	286,800			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,639	332,437	497,076		497,076		497,076			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		164,639	379,522	544,161		544,161		544,161			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,364,355	516,753	2,128,078	5,009,186		5,009,186	(358,965)	4,650,221			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	(31,047)	30		9
10	Interest and Other Investment Income	(1,094)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,730)	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	(726)	21		18
19	Entertainment	(42,087)	20		19
20	Contributions	(4,508)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,612)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,041)	27		24
25	Fund Raising, Advertising and Promotional	(20,297)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,204)	20		28
29	Other-Attach Schedule	(28,556)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (259,902)		\$	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)	(99,063)	PG 6-6C	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (99,063)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (358,965)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0044172

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$	6	1
2	VACATION ACCRUAL	1,755	1	2
3	VACATION ACCRUAL	(45)	3	3
4	VACATION ACCRUAL	581	4	4
5	VACATION ACCRUAL	197	6	5
6	VACATION ACCRUAL	6,649	10	6
7	VACATION ACCRUAL	1,372	11	7
8	VACATION ACCRUAL	(30,045)	17	8
9	VACATION ACCRUAL	(1,125)	21	9
10	PINNACLE CONSULTING (ADVERTISING)	(5,895)	19	10
11	WISCONSIN PHYSICIANS		19	11
12	MEDICARE A CONSULTANT	(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	<b>Total</b>	(28,556)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	1,755	0	0	0	0	0	0	0	0	0	0	1,755	1
2	Food Purchase	(1,730)	0	0	0	0	0	0	0	0	0	0	(1,730)	2
3	Housekeeping	(45)	0	0	0	0	0	0	0	0	0	0	(45)	3
4	Laundry	581	0	0	0	0	0	0	0	0	0	0	581	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	197	0	0	0	0	0	0	0	0	0	0	197	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>758</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>758</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	6,649	0	11,601	0	0	0	0	0	0	0	0	18,250	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,372	0	0	0	0	0	0	0	0	0	0	1,372	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>8,021</b>	<b>0</b>	<b>11,601</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>19,622</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(30,045)	(110,536)	0	0	(110,536)	0	0	0	0	0	0	(251,117)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,507)	68,828	519	(118,231)	0	0	0	0	0	0	0	(59,391)	19
20	Fees, Subscriptions & Promotions	(71,096)	99	32	322	0	0	0	0	0	0	0	(70,643)	20
21	Clerical & General Office Expenses	(1,851)	5,589	1,154	108,501	0	0	0	0	0	0	0	113,393	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,733	2,293	3,154	0	0	0	0	0	0	0	7,180	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	744	1,010	1,415	0	0	0	0	0	0	0	3,169	26
27	Other (specify):*	(123,041)	0	0	0	0	0	0	0	0	0	0	(123,041)	27
28	<b>TOTAL General Administration</b>	<b>(236,540)</b>	<b>(33,543)</b>	<b>5,008</b>	<b>(4,839)</b>	<b>(110,536)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(380,450)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(227,761)</b>	<b>(33,543)</b>	<b>16,609</b>	<b>(4,839)</b>	<b>(110,536)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(360,070)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(31,047)	556	198	2,275	0	0	0	0	0	0	0	(28,018)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,094)	0	0	0	0	0	0	0	0	0	0	(1,094)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	874	23,045	0	0	0	0	0	0	0	23,919	34
35	Rent-Equipment & Vehicles	0	2,939	2,631	728	0	0	0	0	0	0	0	6,298	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(32,141)</b>	<b>3,495</b>	<b>3,703</b>	<b>26,048</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,105</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>(259,902)</b>	<b>(30,048)</b>	<b>20,312</b>	<b>21,209</b>	<b>(110,536)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(358,965)</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		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	\$ 110,536	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		\$	(110,536)	1
2	V	19 PROFESSIONAL FEES		" "		68,828	68,828	2
3	V	20 DUES & SUBSCRIPTIONS		" "		99	99	3
4	V	21 CLERICAL		" "		5,589	5,589	4
5	V	24 TRAVEL		" "		1,733	1,733	5
6	V	26 INSURANCE		" "		744	744	6
7	V	35 RENT - EQPT & VEHICLES		" "		2,939	2,939	7
8	V	30 DEPRECIATION		" "		556	556	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 110,536			\$ 80,488	\$ * (30,048)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10	NURSING	\$ 48,449	CARLYLE NURSING ASSOCIATES, LLC		\$ 60,050	\$ 11,601	15	
16	V	19	PROFESSIONAL FEES		" "		519	519	16	
17	V	20	DUES & SUBSCRIPTIONS		" "		32	32	17	
18	V	21	CLERICAL		" "		1,154	1,154	18	
19	V	24	TRAVEL		" "		2,293	2,293	19	
20	V	26	INSURANCE		" "		1,010	1,010	20	
21	V	30	DEPRECIATION		" "		198	198	21	
22	V	34	RENT		" "		874	874	22	
23	V	35	RENT - EQPT & VEH		" "		2,631	2,631	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			\$ 48,449			\$ 68,761	\$ *	20,312	39

\* 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		\$ 1,327	\$ (118,231)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		322	322	16
17	V	21	CLERICAL		" "		108,501	108,501	17
18	V	24	TRAVEL		" "		3,154	3,154	18
19	V	26	INSURANCE		" "		1,415	1,415	19
20	V	30	DEPRECIATION		" "		2,275	2,275	20
21	V	34	RENT		" "		23,045	23,045	21
22	V	35	RENT - EQPT & VEH		" "		728	728	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			\$ 119,558			\$ 140,767	\$ * 21,209	39

\* 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	\$ 110,536	CHESTERFIELD, LLC		\$	\$ (110,536)	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			\$ 110,536			\$ 0	\$ * (110,536)	39

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

Facility Name &amp; ID Number

MAPLE CREST CARE CENTRE

#

0044172

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WITTINGHAM MANAGEMENT ASSOC.  
 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	355,386	7	\$ 829,056	\$ 29,504	\$ 68,828	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	355,386	7	1,188	29,504	99	2
3	21	CLERICAL	PATIENT DAYS	355,386	7	67,323	29,504	5,589	3
4	24	TRAVEL	PATIENT DAYS	355,386	7	20,875	29,504	1,733	4
5	26	INSURANCE	PATIENT DAYS	355,386	7	8,960	29,504	744	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	355,386	7	35,397	29,504	2,939	6
7	30	DEPRECIATION	PATIENT DAYS	355,386	7	6,701	29,504	556	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					\$ 969,500	\$	\$ 80,488	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

# 0044172 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CARLYLE NURSING ASSOC. LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, 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	10	NURSING	DIRECT HOURS	1	\$ 60,050	\$ 60,050	1	\$ 60,050	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	9,653	29,504	519	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	603	29,504	32	3
4	21	CLERICAL	PATIENT DAYS	549,185	11	21,492	29,504	1,154	4
5	24	TRAVEL	PATIENT DAYS	549,185	11	42,708	29,504	2,293	5
6	26	INSURANCE	PATIENT DAYS	549,185	11	18,809	29,504	1,010	6
7	30	DEPRECIATION	PATIENT DAYS	549,185	11	3,694	29,504	198	7
8	34	RENT	PATIENT DAYS	549,185	11	16,279	29,504	874	8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	549,185	11	48,990	29,504	2,631	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				\$ 222,278	\$ 60,050		\$ 68,761	25

Facility Name & ID Number MAPLE CREST CARE CENTRE

# 0044172 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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 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

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	549,185	11	\$ 24,702	\$ 29,504	\$ 1,327	1	
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	6,002	29,504	322	2	
3	21	CLERICAL	PATIENT DAYS	549,185	11	215,149	29,504	11,558	3	
4	24	TRAVEL	PATIENT DAYS	549,185	11	58,719	29,504	3,154	4	
5	26	INSURANCE	PATIENT DAYS	549,185	11	26,340	29,504	1,415	5	
6	30	DEPRECIATION	PATIENT DAYS	549,185	11	42,349	29,504	2,275	6	
7	34	RENT	PATIENT DAYS	549,185	11	428,990	29,504	23,045	7	
8	35	RENT - EQPT & VEH	PATIENT DAYS	549,185	11	13,546	29,504	728	8	
9	21	CLERICAL	DIRECT HOURS	1	1	96,943	96,943	1	96,943	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					\$ 912,740	\$ 96,943	\$ 140,767	25	

Facility Name & ID Number MAPLE CREST CARE CENTRE

# 0044172

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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										
										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																			
2																			
3																			
4																			
5																			
<b>Working Capital</b>																			
6	<b>MEMBER LOANS</b>	<b>X</b>		<b>WORKING CAPITAL</b>	<b>DEMAND</b>	<b>VARIES</b>	<b>150,000</b>	<b>338,899</b>	<b>DEMAND</b>	<b>VARIES</b>	<b>24,376</b>								
7	<b>RELATED PARTY</b>	<b>X</b>		<b>WORKING CAPITAL</b>	<b>DEMAND</b>	<b>VARIES</b>	<b>721,000</b>	<b>601,123</b>	<b>DEMAND</b>	<b>VARIES</b>									
8																			
9	<b>TOTAL Facility Related</b>						<b>\$ 871,000</b>	<b>\$ 940,022</b>			<b>\$ 24,376</b>								
<b>B. Non-Facility Related*</b>																			
10	<b>IRS, IDR, ETC</b>		<b>X</b>	<b>LATE FEES</b>															
11																			
12																			
13																			
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>								
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 871,000</b>	<b>\$ 940,022</b>			<b>\$ 24,376</b>								

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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>45,700</b>	<b>1</b>
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>45,731</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>31</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>48,000</b>	<b>4</b>
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>		\$		<b>5</b>
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>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>48,031</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>30,884</b>	<b>8</b>
	2005	<b>31,506</b>	<b>9</b>
	2006	<b>46,948</b>	<b>10</b>
	2007	<b>45,168</b>	<b>11</b>
	2008	<b>45,731</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 105% OF THE PRIOR YEAR REAL ESTATE TAX IS BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL**

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
14	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
15	LESS REFUND FROM LINE 6	\$	<b>15</b>
16	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**



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

# **0044172**

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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>NURSINGHOME</u>	<u>653,400</u>		\$	1
2					2
3	<b>TOTALS</b>	<b>653,400</b>		\$	3

Facility Name & ID Number MAPLE CREST CARE CENTRE# 0044172

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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
	<b>Improvement Type**</b>										
9		WALL COVERING/BORDERS/VINYL COVERINGS	1999		17,944		7			17,944	9
10		STEEL DOORS	1999		2,337	85	27.5	85		906	10
11		SIGN, SIGN FOOTINGS AND BRICKS	1999		4,652	169	27.5	169		1,713	11
12		REMODEL - DINING & REC. ROOMS, OFFICES, HALLS	1999		73,951	2,689	27.5	2,689		27,452	12
13		CONDENSING UNIT FOR WALK IN FREEZER	2000		3,695	134	27.5	134		1,226	13
14		WATER SOFTENER UNIT	2000		10,120	368	27.5	368		3,358	14
15		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS	2001		11,239	409	27.5	409		3,662	15
16		TWO HOT WATER HEATERS	2001		13,065	475	27.5	475		4,256	16
17		REMOVAL OF WATER TANKS & PIPING	2001		7,650	278	27.5	278		2,468	17
18		REPAIRS TO GRAVEL ROOF	2001		2,875	105	27.5	105		901	18
19		BLACK TOP PARKING LOT	2001		1,270	46	27.5	46		398	19
20		AIRCONDITIONING - REPAIRS & INSTALLATION - DINING RM	2001		7,430	270	27.5	270		2,307	20
21		ASBESTOS ABATEMENT/FLOOR RENOVATION	2001		1,400	51	27.5	51		433	21
22		REPLACE WATER COIL - FOOD STORAGE AREA	2001		7,500	273	27.5	273		2,284	22
23		INSTALL CONTROL DAMPER IN BATHING AREA	2001		1,795	65	27.5	65		536	23
24		BOILER ROOM EXHAUST FAN	2001		1,980	72	27.5	72		591	24
25		REPLACE DAMPER ON GENERATOR	2001		1,260	46	27.5	46		373	25
26		ADDITON OF 6 BEDS - GENERAL CONST./WINDOWS/PAINTING	2001		103,815	3,775	27.5	3,775		30,673	26
27		EXHAUST FANS FOR KITCHEN & DISHWASHING AREA	2001		5,894	214	27.5	214		1,742	27
28		AIR CONDITIONING CONDENSING UNIT	2002		8,557	311	27.5	311		2,386	28
29		ROOF REPAIR OVER LAUNDRY RM, RMS 212, & 114 & FOYER	2002		9,800	356	27.5	356		2,673	29
30		ROOF REPAIRS	2002		2,030	74	27.5	74		529	30
31		ARCHITECTURAL DRAWINGS FOR ADDING 2 BEDS	2003		5,607	204	27.5	204		1,325	31
32		CONSTRUCTION OF 2 BED ADDITION - FROM 84 BEDS TO 86	2003		76,097	2,767	27.5	2,767		17,987	32
33		ROOF REPAIRS IN THE VALLEY, LAUNDRY RM & BEAUTY SALO	2003		4,627	168	27.5	168		1,094	33
34		NEW A/C UNIT IN DINING ROOM	2003		16,997	618	27.5	618		4,017	34
35		25 TON BRYANT CONDENSING UNIT - OFFICE AREA	2004		10,620	386	27.5	386		2,156	35
36		ELECTRICAL REPAIRS ON CONDUITS IN KITCHEN FLR.	2004		4,407	160	27.5	160		868	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:

01/01/2009 Ending: 12/31/2009

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 REMOVE OLD TILE AND INSTALL NEW ONES IN KITCHEN	2004	\$ 1,400	\$ 51	27.5	\$ 51	\$	\$ 276	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		1,970	39
40 KITCHEN TILES - BEHIND DISHWASHER AND SINKS	2005	1,500	55	27.5	55		273	40
41 WALLCOVERINGS, DRAPES, CUBICLE CURTAINS - RES. RM	2006	41,904	4,827	10	4,190	(637)	20,952	41
42 CORRIDOR CEILING UPGRADES	2006	23,625	859	27.5	859		3,186	42
43 REMOVE & INSTALL TILES & HAND RAILS - 100, 200 WING	2006	45,000	1,636	27.5	1,636		5,795	43
44 REPAIR DOORS, INSTALL CARPET & WALLPAPER - 100 WI	2006	20,000	2,304	10	2,000	(304)	10,000	44
45 INSTALL 5 EXTERIOR WALL PACKS FLOOD LAMPS	2006	1,714	62	27.5	62		221	45
46 INSTALL 460' DECO SHIELD FOR NEW PIPING	2006	4,388	160	27.5	160		565	46
47 INSTALL SWEAGE PUMP	2006	7,391	269	27.5	269		929	47
48 REPLACED FIRE ALARM PANEL	2006	4,730	172	27.5	172		566	48
49 NEW NURSES WORK STATIONS & SECURITY CAMERAS	2006	11,486	418	27.5	418		1,375	49
50 VCT FLOORING FOR NURSES STATIONS & REC. ROOM	2006	2,533	92	27.5	92		295	50
51 REPLACE 175 FT OF 4" SEWER BETWEEN EAST & WEST								51
52 MANHOLE	2007	4,260	155	27.5	155		452	52
53 BLINDS, WALLCOVERINGS, AWNING FOR SHOWCASE	2007	4,215	153	27.5	153		421	53
54 DRYWALL, PAINTING, TILING - THERAPY ROOM, BATHRO	2008	15,375	559	27.5	559		839	54
55 TILES FOR REHAB ROOM	2008	14,203	516	27.5	516		775	55
56 SHELVING, WALLPAPER, DRYWALL - KITCHEN	2008	12,200	444	27.5	444		665	56
57 SPRINKLER HEADS	2008	1,938	70	27.5	70		106	57
58 MIXING VAVLES & TILES	2008	2,780	101	27.5	101		143	58
59 DIFFUSERS	2008	1,624	59	27.5	59		84	59
60 DRYWALL, PAINTING, TILING - BREAKROOM	2008	21,720	790	27.5	790		1,118	60
61 PHONE, JACKS & NETWORK CABLES - OFFICES	2008	1,917	70	27.5	70		98	61
62 SPRINKLER HEADS	2008	595	22	27.5	22		30	62
63 CERAMIC TILES - BATHROOMS	2008	1,063	39	27.5	39		52	63
64 WINDOWS FOR THERAPY ROOM	2008	1,482	54	27.5	54		72	64
65 FLOORING - THERAPY ROOM	2008	4,508	164	27.5	164		219	65
66 SHOWER ROOMS - TILES & PAINTING	2008	3,373	123	27.5	123		133	66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 685,538	\$ 29,156		\$ 28,215	\$ (941)	\$ 187,868	70

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

Facility Name & ID Number MAPLE CREST CARE CENTRE

# 0044172

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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	\$ 482,080	\$ 35,706	\$ 46,032	\$ 10,326	3-15 YRS	\$ 277,675	71
72	Current Year Purchases	77,621	42,702	2,270	(40,432)	3-15 YRS	2,270	72
73	Fully Depreciated Assets	15,390				3-15 YRS	15,390	73
74	<u>RELATED PARTY</u>		3,029	3,029				74
75	<b>TOTALS</b>	\$ 575,091	\$ 81,437	\$ 51,331	\$ (30,106)		\$ 295,335	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)	\$ 1,260,629	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 110,593	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,546	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,047)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 483,203	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.

Facility Name & ID Number MAPLE CREST CARE CENTRE

STATE OF ILLINOIS

# 0044172

Report Period Beginning:

01/01/2009

Ending: 12/31/2009

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: COUNTY OF BOONE

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>78</u>	<u>02/01/99</u>	\$ <u>94,595</u>	<u>30</u>		<u>3</u>
4	Additions	<u>12/11/2001</u>	<u>6</u>					<u>4</u>
5		<u>5/13/2003</u>	<u>2</u>					<u>5</u>
6								<u>6</u>
7	<b>TOTAL</b>		<b>86</b>		\$ <b>94,595</b>			<b>7</b>

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.	<u>12/31/2010</u>	\$ <u>98,379</u>
13.	<u>12/31/2011</u>	\$ <u>102,314</u>
14.	<u>12/31/2012</u>	\$ <u>106,406</u>

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: \$ 11,129

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	\$		\$ 160,211	\$		\$ 160,211	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,379			11,379	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			160,847			160,847	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				138,380		138,380	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): <b>RENTALS</b>	39-2					26,259		26,259	13
14	<b>TOTAL</b>			\$		\$ 332,437	\$ 164,639		\$ 497,076	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# 0044172Report Period Beginning: 01/01/2009

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2009

(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	\$ 363,561	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 253,800 )	648,476		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,224		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	242,550		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,289,811	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			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	575,091		16
17	Accumulated Depreciation (book methods)	(700,707)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 559,921	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,849,732	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 151,580	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,077		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,344		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>MANAGEMENT FEES</u>	30,380		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 317,381	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	940,022		39
40	Mortgage Payable			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>	\$ 940,022	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,257,403	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 592,329	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,849,732	\$	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>69,249</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING ADJ.</b>	<b>4</b>	<b>3</b>
<b>4</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>69,253</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>648,076</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>(125,000)</b>	<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>523,076</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>592,329</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	\$ 5,670,017	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,670,017</b>	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>	<b>\$</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		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>	<b>\$</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,094	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,094</b>	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>	<b>\$</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,671,111</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	792,096	31
32	Health Care	1,902,548	32
33	General Administration	1,484,686	33
<b>B. Capital Expense</b>			
34	Ownership	285,695	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	497,076	35
36	Provider Participation Fee	47,085	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>	<b>13,849</b>	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,023,035</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>648,076</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 648,076</b>	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:

01/01/2009

Ending:

12/31/2009

**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	2,052	2,180	\$ 78,611	\$ 36.06	1
2	Assistant Director of Nursing	2,037	2,204	66,909	30.36	2
3	Registered Nurses	6,620	7,945	226,022	28.45	3
4	Licensed Practical Nurses	16,668	18,559	454,260	24.48	4
5	CNAs & Orderlies	50,534	56,468	627,312	11.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,937	6,687	111,727	16.71	8
9	Activity Director	2,300	2,424	40,480	16.70	9
10	Activity Assistants	4,904	5,261	42,384	8.06	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,535	3,902	79,812	20.45	13
14	Head Cook	2,901	3,144	29,591	9.41	14
15	Cook Helpers/Assistants	8,309	9,564	84,345	8.82	15
16	Dishwashers					16
17	Maintenance Workers	3,946	4,277	67,167	15.70	17
18	Housekeepers	7,025	7,890	63,910	8.10	18
19	Laundry	6,571	7,035	57,394	8.16	19
20	Administrator	1,891	3,059	128,177	41.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,957	2,139	33,766	15.79	23
24	Clerical	3,749	4,106	76,437	18.62	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					31
32	Other Health Care <u>CLERICAL</u>	3,462	4,047	96,051	23.73	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	134,398	150,891	\$ 2,364,355 *	\$ 15.67	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	156	\$ 7,668	1-3	35
36	Medical Director	54	10,800	9-3	36
37	Medical Records Consultant	12	630	10-3	37
38	Nurse Consultant	281	49,258	10-3	38
39	Pharmacist Consultant	196	4,509	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	16	1,107	11-3	44
45	Social Service Consultant	50	3,639	12-3	45
46	Other(specify) _____				46
47					47
48					48
49	TOTAL (lines 35 - 48)	765	\$ 77,611		49

**C. CONTRACT NURSES**

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



Facility Name & ID Number MAPLE CREST CARE CENTRE

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

**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. - \$6552
- (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. \$ 10,158 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,085  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
  - d. Have vehicle usage logs been maintained? NO
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
  - g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (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.