

Facility Name & ID Number Maplewood Care

0040428 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	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	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>38,116</u>	<u>1,235</u>	<u>2,403</u>	<u>41,754</u>	8	
9	SNF/PED					9	
10	ICF	<u>26,312</u>	<u>711</u>		<u>27,023</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>64,428</u>	<u>1,946</u>	<u>2,403</u>	<u>68,777</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.82%

D. How many bed-hold days during this year were paid by the Department? 1,762 (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 04/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 203 and days of care provided 1,706

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	252,997	29,510	38,934	321,441		321,441	(15,319)	306,122		1
2	Food Purchase		319,010		319,010	(31,963)	287,047	(90)	286,957		2
3	Housekeeping	206,916	38,042		244,958		244,958	(1,604)	243,354		3
4	Laundry	77,840	18,035		95,875		95,875	(669)	95,206		4
5	Heat and Other Utilities			198,447	198,447		198,447	(17,400)	181,047		5
6	Maintenance	87,570	22,901	169,963	280,434		280,434	(20,650)	259,784		6
7	Other (specify):*							2,425	2,425		7
8	TOTAL General Services	625,323	427,498	407,344	1,460,165	(31,963)	1,428,202	(53,307)	1,374,895		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,179,072	158,009	293,735	2,630,816		2,630,816	(32,522)	2,598,294		10
10a	Therapy	168,212	7,502	26,074	201,788		201,788	(16,366)	185,422		10a
11	Activities	107,333	13,809	2,400	123,542		123,542		123,542		11
12	Social Services	229,121		10,970	240,091		240,091		240,091		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,326	4,326		15
16	TOTAL Health Care and Programs	2,683,738	179,320	340,379	3,203,437		3,203,437	(44,562)	3,158,875		16
	C. General Administration										
17	Administrative	79,825		512,522	592,347		592,347	(387,762)	204,585		17
18	Directors Fees										18
19	Professional Services			276,922	276,922		276,922	(227,812)	49,110		19
20	Dues, Fees, Subscriptions & Promotions			83,970	83,970		83,970	(56,332)	27,638		20
21	Clerical & General Office Expenses	237,727	36,164	238,163	512,054		512,054	(68,880)	443,174		21
22	Employee Benefits & Payroll Taxes			475,021	475,021	31,963	506,984		506,984		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,535	4,535		4,535	136	4,671		24
25	Other Admin. Staff Transportation			8,297	8,297		8,297	9,634	17,931		25
26	Insurance-Prop.Liab.Malpractice			151,924	151,924		151,924	1,281	153,205		26
27	Other (specify):*							42,542	42,542		27
28	TOTAL General Administration	317,552	36,164	1,751,354	2,105,070	31,963	2,137,033	(687,193)	1,449,840		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,626,613	642,982	2,499,077	6,768,672		6,768,672	(785,062)	5,983,610		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Maplewood Care

#0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			84,739	84,739		84,739	189,287	274,026			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,531	39,531		39,531	360,436	399,967			32
33	Real Estate Taxes							104,821	104,821			33
34	Rent-Facility & Grounds			804,000	804,000		804,000	(804,000)				34
35	Rent-Equipment & Vehicles			6,489	6,489		6,489	9,523	16,012			35
36	Other (specify):*							(0)	(0)			36
37	TOTAL Ownership			934,759	934,759		934,759	(139,933)	794,826			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,303	267,618	343,921		343,921	(712)	343,209			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		76,303	378,761	455,064		455,064	(712)	454,352			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,626,613	719,285	3,812,597	8,158,495		8,158,495	(925,707)	7,232,788			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(19,779)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	162,023	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(90)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(21,840)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(156,466)	21		24
25	Fund Raising, Advertising and Promotional	(17,408)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,547)	20		28
29	Other-Attach Schedule	(161,786)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (231,895)		\$	30

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)	(693,812)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (693,812)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (925,707)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Maplewood Care

ID# 0040428

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	COPE Dues	\$ (5,684)	20	1
2	Bank Fees	(2,723)	21	2
3	Theft & Damage Loss	(2,059)	21	3
4	Capitalized R&M	(17,899)	06	4
5	Collections	(350)	21	5
6	Title Fees	(150)	20	6
7	Non Allowable Seminar Expense	(265)	24	7
8	Amortization - Building Co.	(38,017)	36	8
9	Filing Fees - Building Co.	(309)	20	9
10	Office Expense - Building Co.	(108)	21	10
11	Professional Fees - Building Co.	(1,164)	19	11
12	Additional R&M	7,895	06	12
13	Non-Allowable Legal Expense	(100,954)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(161,786)		49

Maplewood Care

ID# 0040428
 Report Period Beginning: 01/01/09
 Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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				(15,319)								(15,319)	1
2	Food Purchase	(90)											(90)	2
3	Housekeeping					(1,604)							(1,604)	3
4	Laundry					(669)							(669)	4
5	Heat and Other Utilities	(19,779)			2,379								(17,400)	5
6	Maintenance	(10,004)		(10,180)	(463)	(3)							(20,650)	6
7	Other (specify):*			943	1,482								2,425	7
8	TOTAL General Services	(29,873)		(9,237)	(11,921)	(2,276)							(53,307)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(28,573)	7,566	(8,051)		(3,464)					(32,522)	10
10a	Therapy				(16,366)								(16,366)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,304	2,022								4,326	15
16	TOTAL Health Care and Programs			(26,269)	(6,778)	(8,051)		(3,464)					(44,562)	16
	C. General Administration													
17	Administrative			(475,332)	87,570								(387,762)	17
18	Directors Fees													18
19	Professional Services	(102,117)	1,164	(142,174)	15,315								(227,812)	19
20	Fees, Subscriptions & Promotions	(56,938)	309	297									(56,332)	20
21	Clerical & General Office Expenses	(166,706)	108	97,649	69								(68,880)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(265)		401									136	24
25	Other Admin. Staff Transportation			9,634									9,634	25
26	Insurance-Prop.Liab.Malpractice			1,140	141								1,281	26
27	Other (specify):*			24,902	17,640								42,542	27
28	TOTAL General Administration	(326,026)	1,581	(483,483)	120,735								(687,193)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(355,899)	1,581	(518,989)	102,036	(10,327)		(3,464)					(785,062)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	162,023	15,870		11,394								189,287	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2)	378,387	(25,400)	7,451								360,436	32
33	Real Estate Taxes		97,692		7,129								104,821	33
34	Rent-Facility & Grounds		(804,000)										(804,000)	34
35	Rent-Equipment & Vehicles			9,523									9,523	35
36	Other (specify):*	(38,017)	38,017										(0)	36
37	TOTAL Ownership	124,004	(274,034)	(15,877)	25,974								(139,933)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(712)					(712)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers							(712)					(712)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(231,895)	(272,453)	(534,866)	128,010	(10,327)		(4,176)					(925,707)	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		See Attached		See Attached		
				Maplewood - Jane, LLC		Bldg. Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 804,000	Maplewood-Jane, LLC	100.00%	\$	\$ (804,000)	1
2	V	32 Interest Income	27,852	Maplewood-Jane, LLC	100.00%		(27,852)	2
3	V	36 Amortization		Maplewood-Jane, LLC	100.00%	38,017	38,017	3
4	V	30 Depreciation		Maplewood-Jane, LLC	100.00%	15,870	15,870	4
5	V	20 Filing Fees		Maplewood-Jane, LLC	100.00%	309	309	5
6	V	32 Interest Expense		Maplewood-Jane, LLC	100.00%	406,239	406,239	6
7	V	21 Office Expense		Maplewood-Jane, LLC	100.00%	108	108	7
8	V	19 Professional Fees		Maplewood-Jane, LLC	100.00%	1,164	1,164	8
9	V	33 Real Estate Taxes		Maplewood-Jane, LLC	100.00%	97,692	97,692	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 831,852			\$ 559,399	\$ * (272,453)	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	6 REPAIRS AND MAINT.	\$ 21,924	S.I.R. MANAGEMENT, INC.	100.00%	\$ 11,744	\$ (10,180)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	943	943
17	V	10 NURSING	43,848	S.I.R. MANAGEMENT, INC.	100.00%	15,275	(28,573)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,304	2,304
19	V	19 PROFESSIONAL FEES	145,572	S.I.R. MANAGEMENT, INC.	100.00%	2,556	(143,016)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	297	297
21	V	21 CLERICAL & GENERAL	43,848	S.I.R. MANAGEMENT, INC.	100.00%	34,997	(8,851)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	401	401
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,634	9,634
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,140	1,140
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,481	4,481
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(25,400)	(25,400)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,523	9,523
28	V						
29	V	17 ADMINISTRATIVE	501,554	S.I.R. MANAGEMENT, INC.	100.00%	26,222	(475,332)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	842	842
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	106,500	106,500
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,421	20,421
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 756,746			\$ 221,880	\$ * (534,866)

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

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/09 Ending: 12/31/09

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	1	DIETARY SALARIES	\$ 21,924	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,605	\$ (15,319)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,020	1,020	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,566	7,566	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,150	1,150	18
19	V	17	ADMIN./LEGAL SALARIES	10,968	S.I.R. MANAGEMENT, INC.	100.00%	98,538	87,570	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	15,257	15,257	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	17,640	17,640	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	21,924	S.I.R. MANAGEMENT, INC.	100.00%	5,558	(16,366)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	872	872	25
26	V								26
27	V	6	MAINTENANCE SALARIES	3,680	S.I.R. MANAGEMENT, INC.	100.00%	2,536	(1,144)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	462	462	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,379	2,379	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	681	681	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	58	58	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	69	69	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	141	141	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	11,394	11,394	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,451	7,451	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,129	7,129	37
38	V								38
39	Total		\$ 58,496				\$ 186,506	\$ * 128,010	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	17,471	Xcel Supply, LLC	100.00%	15,867	(1,604)	16
17	V	4 Laundry	7,288	Xcel Supply, LLC	100.00%	6,618	(669)	17
18	V	6 Repairs & Maintenance	29	Xcel Supply, LLC	100.00%	26	(3)	18
19	V	10 Nursing	87,667	Xcel Supply, LLC	100.00%	79,616	(8,051)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 112,454			\$ 102,127	\$ * (10,327)	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 109,142	\$ 109,142	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	109,142	CCS Employee Benefits Group	100.00%		(109,142)	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		\$ 109,142			\$ 109,142	\$ *	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	39 Enterals	\$ 1,660	Care Centers Health Systems, Inc.		\$ 948	\$ (712)
16	V	10 Infusion Supplies	8,073	Care Centers Health Systems, Inc.		4,609	(3,464)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,733			\$ 5,557	\$ * (4,176)

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V						\$	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		\$			\$	\$ *	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		\$			\$	\$	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		\$			\$	\$ *	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		\$			\$	\$	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		\$			\$	\$ *	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		\$			\$	\$	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		\$			\$	\$ *	39

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

Facility Name & ID Number

Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Bryan Barrish	Relative	Administrative	12.88%	See Attached	2.56	6.40%	Alloc. Salary	\$ 16,636	17-7	1
2	Michael Giannini	Relative	Administrative	10.42%	See Attached	2.99	7.48%	Alloc. Salary	14,242	17-7	2
3	Eric Rothner	Relative	Administrative	N/A	See Attached	0.60	1.29%	Alloc. Salary	8,531	17-7	3
4	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.27	8.54%	Alloc. Salary	6,605	1-7	4
5	Louise Bergthold	Shareholder	Administrative	5.92%	See Attached	4.69	8.53%	Alloc. Salary	16,636	17-7	5
6	Tom Winter	Shareholder	Administrative	2.71%	See Attached	4.90	8.17%	Alloc. Salary	15,935	17-7	6
7	Jeff Oravec	Shareholder	Administrative	0.49%	See Attached	3.27	8.18%	Alloc. Salary	10,287	17-7	7
8	Joey Abramchik	Shareholder	Administrative	0.49%	See Attached	3.84	8.53%	Alloc. Salary	15,257	17-7	8
9	Elka Abramchik	Relative	Clerical	N/A	See Attached	2.86	8.17%	Alloc. Salary	2,904	21-7	9
10	Kirsten Barrish	Relative	Clerical	N/A	See Attached	1.45	8.53%	Alloc. Salary	1,153	21-7	10
11	Sarrah Barrish	Relative	Administrative	N/A	See Attached	3.41	8.53%	Alloc. Salary	8,699	17-7	11
12	Adam Vales	Relative	Clerical	2.96%	See Attached	0.64	1.60%	Alloc. Salary	1,145	22-7	12
13								TOTAL	\$ 118,030		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 S.I.R. MANAGEMENT, INC.
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

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	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	68,777	\$ 11,744	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		68,777	943	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	68,777	15,275	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		68,777	2,304	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	68,777	2,556	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		68,777	297	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	68,777	34,997	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		68,777	401	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		68,777	9,634	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		68,777	1,140	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		68,777	4,481	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		68,777	(25,400)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		68,777	9,523	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	68,777	26,222	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		68,777	842	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	68,777	106,500	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		68,777	20,421	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 221,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/09Ending: 12/31/09

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

S.I.R. MANAGEMENT, INC.

Street Address

6840 N. LINCOLN

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 675 -7979

Fax Number

(847) 675 -0555

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	1	DIETARY SALARIES	PATIENT DAYS	806,183	12	\$ 77,418	\$ 77,418	68,777	\$ 6,605	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962	68,777	1,020		2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	7,566		3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479	68,777	1,150		4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	98,538		5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836	68,777	15,257		6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767	68,777	17,640		7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	5,558		10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868	21,924	872		11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	2,536		13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348	3,680	462		14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260	1,084	2,379		16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091	1,084	681		17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689	1,084	58		18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822	1,084	69		19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678	1,084	141		20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367	1,084	11,394		21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526	1,084	7,451		22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702	1,084	7,129		23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963	\$ 186,506		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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.

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	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					15,867	2
3	4	Laundry	Direct Allocation					6,618	3
4	6	Repairs & Maintenance	Direct Allocation					26	4
5	10	Nursing	Direct Allocation					79,616	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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				\$	\$		\$	102,127

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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.

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 109,142	1
2									2
3									3
4									4
5									5
6									6
7									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				\$	\$		\$ 109,142	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Care Centers Health Systems, Inc.

Street Address

200 Howard

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(224) 612-5662

Fax Number

(224) 612-5862

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.

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	39	Enterals	Direct Allocation		\$	\$		\$ 948	1
2	10	Infusion Supplies	Direct Allocation					4,609	2
3									3
4									4
5									5
6									6
7									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				\$	\$		\$ 5,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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									1
2									2
3									3
4									4
5									5
6									6
7									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Alloc. - Maplewood Care		X	Note Payable			\$	\$ 8,728,975		\$ 406,239	1									
2	Shareholder Loan	X		Note Payable				1,600,000			2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Lake Forest Bank		X	Line of Credit				695,000		39,531	6									
7	Alloc. SIR Management	X								(17,949)	7									
8	See Supplemental Schedule										8									
9	TOTAL Facility Related						\$	\$ 11,023,975		\$ 427,821	9									
B. Non-Facility Related*																				
10	Interest Income		X							(2)	10									
11	Bldg. Partnership Int. Income		X							(27,852)	11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		\$ (27,854)	14									
15	TOTALS (line 9+line14)						\$	\$ 11,023,975		\$ 399,967	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,780 B. General Construction Type: Exterior Brick Frame _____ 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).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>517,253</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 517,253	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	Various		1993		98,204		20	2,160	2,160	60,161	9
10	Various		1994		13,684		20	684	684	11,208	10
11	Various		1995		5,179		20	259	259	3,746	11
12	Various		1996		19,800		20	990	990	13,695	12
13	Various		1997		21,688		20	1,085	1,085	13,936	13
14	Various		1998		19,077		20	955	955	10,767	14
15	Various		1999		47,028		20	2,195	2,195	22,770	15
16	Various		2000		565,082		20	28,254	28,254	277,417	16
17	Various		2001		72,848		20	4,367	4,367	39,663	17
18	Various		2002		15,524		20	1,282	1,282	9,946	18
19	Various		2003		22,349		20	1,119	1,119	7,386	19
20	Various		2004		18,088		20	1,099	1,099	5,879	20
21	Various		2005		114,777		20	5,739	5,739	25,586	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09**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		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67	<u>Related Building Company (Pages 12F & 12G)</u>		<u>5,445,306</u>	<u>15,870</u>		<u>155,580</u>	<u>139,710</u>	<u>2,563,464</u>	67
68	<u>Related Party Allocations (Pages 12H & 12I)</u>		<u>135,068</u>	<u>5,538</u>		<u>4,354</u>	<u>(1,184)</u>	<u>55,684</u>	68
69	<u>Financial Statement Depreciation</u>			<u>84,739</u>			<u>(84,739)</u>		69
70	TOTAL (lines 4 thru 69)		\$ 6,613,702	\$ 106,147		\$ 210,122	\$ 103,975	\$ 3,121,308	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	
1	Totals from Page 12A, Carried Forward		\$ 6,613,702	\$ 106,147		\$ 210,122	\$ 103,975	\$ 3,121,308	1
2	Sidewalk	2006	4,500		20	225	225	881	2
3	Roof	2006	246,800		20	12,340	12,340	43,190	3
4	Bathroom Work	2006	12,700		20	635	635	2,487	4
5	Plumbing Work	2006	2,655		20	133	133	520	5
6	Bathroom Work	2006	11,675		20	584	584	1,946	6
7	Bathroom Work	2007	13,435		20	672	672	2,015	7
8	Fire Dampers	2007	3,065		20	153	153	421	8
9	Hvac Work	2007	4,050		20	203	203	540	9
10	Water Heater	2007	7,131		20	357	357	743	10
11	Lobby Carpet Tile	2007	3,563		20	178	178	490	11
12	Stop Valves Replacement	2007	3,724		20	186	186	512	12
13	Heating & Cooling Repair	2007	2,823		20	141	141	318	13
14	Elevator Work	2008	8,500		20	425	425	815	14
15	Plumbing Work	2008	13,948		20	358	358	641	15
16	Paving	2008	58,878		20	3,925	3,925	6,542	16
17	Water Heater	2008	7,918		20	792	792	1,320	17
18	Elevator Work	2008	3,060		20	153	153	217	18
19	Window Treatments	2008	12,623		20	2,525	2,525	3,366	19
20	Bathrooms-Plumbing, Walls, Tiles, Electrical, New Fixtures	2008	26,200		20	2,620	2,620	3,493	20
21	Hvac Work	2008	14,200		20	533	533	533	21
22	Isolation Valves / Internal Shower Valves	2008	2,713		20	136	136	249	22
23	Bathrooms-Plumbing, Walls, Tiles, Electrical, New Fixtures	2009	27,600		20	1,380	1,380	1,380	23
24	Pavers	2009	14,800		20	123	123	123	24
25	Hvac Work	2009	2,873		20	144	144	144	25
26	Hvac Work	2009	2,831		20	142	142	142	26
27	Master Key System	2009	2,915		20	194	194	194	27
28	Hvac Work	2009	3,430		20	172	172	172	28
29	Heat Exchanger	2009	2,978		20	596	596	596	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,135,290	\$ 106,147		\$ 240,147	\$ 134,000	\$ 3,195,298	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1		\$ 7,135,290	\$ 106,147		\$ 240,147	\$ 134,000	\$ 3,195,298	1
2								2
3								3
4								4
5								5
6								6
7								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,135,290	\$ 106,147		\$ 240,147	\$ 134,000	\$ 3,195,298	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	
1		\$ 7,135,290	\$ 106,147		\$ 240,147	\$ 134,000	\$ 3,195,298	1
2								2
3								3
4								4
5								5
6								6
7								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,135,290	\$ 106,147		\$ 240,147	\$ 134,000	\$ 3,195,298	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1		\$ 7,135,290	\$ 106,147		\$ 240,147	\$ 134,000	\$ 3,195,298	1
2								2
3								3
4								4
5								5
6								6
7								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,135,290	\$ 106,147		\$ 240,147	\$ 134,000	\$ 3,195,298	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1972	5,445,306	15,870	35	155,580	139,710	2,563,464	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 5,445,306	\$ 15,870		\$ 155,580	\$ 139,710	\$ 2,563,464

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	1993	38,100	1,210		1,089	(121)	17,961	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	2009	2,288	1,307	20	92	(1,215)	92	9
10	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	2007	667	97	20	33	(64)	100	10
11	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	2002	151		20	8	8	57	11
12	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	1999	4,828	241	20	241		2,535	12
13	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	1998	2,307		20	115	115	1,327	13
14	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	1997	144		20	7	7	97	14
15	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	1994	363	9	20	18	9	281	15
16	<u>S.I.R. Properties-S.I.R. Management-Allocation</u>	1993	618	3	20	31	28	510	16
17									17
18	<u>S.I.R. Management - Allocation</u>	1993	9,660	269	20	479	210	8,141	18
19	<u>S.I.R. Management - Allocation</u>	1994	30		20			30	19
20	<u>S.I.R. Management - Allocation</u>	1995	221		20	11	11	159	20
21	<u>S.I.R. Management - Allocation</u>	1997	14,843	332	20	742	410	9,506	21
22	<u>S.I.R. Management - Allocation</u>	1999	1,167		20	58	58	598	22
23	<u>S.I.R. Management - Allocation</u>	1999	11,357		20			11,357	23
24	<u>S.I.R. Management - Allocation</u>	2000	1,378		20	69	69	657	24
25	<u>S.I.R. Management - Allocation</u>	2007	4,427	789	20	221	(568)	486	25
26	<u>S.I.R. Management - Allocation</u>	2008	12,201	1,220	20	769	(451)	1,419	26
27	<u>S.I.R. Management - Allocation</u>	2009	30,318	61	20	371	310	371	27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		
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								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	TOTAL (12H & 12I lines 1 thru 33)		\$ 135,068	\$ 5,538		\$ 4,354	\$ (1,184)	\$ 55,684	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 249,068	\$ 5,676	\$ 30,600	\$ 24,924	10	\$ 473,812	71
72	Current Year Purchases	48,202	179	2,975	2,796	10	2,975	72
73	Fully Depreciated Assets	640,871		303	303	10	31,871	73
74								74
75	TOTALS	\$ 938,141	\$ 5,855	\$ 33,878	\$ 28,023		\$ 508,658	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)	\$ 8,590,684	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,002	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 274,025	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 162,023	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,703,956	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,332 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevy Express Van	\$ 339.97	\$ 1,680	17
18					18
19					19
20					20
21	TOTAL		\$ 339.97	\$ 1,680	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/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>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	113,294	\$		\$	113,294	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				32,162				32,162	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				122,162				122,162	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					65,232			65,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Supplemental							11,071			11,071	13
14	TOTAL			\$		\$	267,618	\$	76,303	\$	343,921	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 19,276	\$ 842,465	1
2	Cash-Patient Deposits	166,010	166,010	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,524,497	1,524,497	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,919	63,919	6
7	Other Prepaid Expenses	2,113	2,113	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>		30,920	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,775,815	\$ 2,629,924	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		517,253	13
14	Buildings, at Historical Cost		2,518,622	14
15	Leasehold Improvements, at Historical Cost	1,007,328	1,007,328	15
16	Equipment, at Historical Cost	1,159,999	1,768,999	16
17	Accumulated Depreciation (book methods)	(1,192,355)	(3,945,789)	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): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 974,972	\$ 1,866,413	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,750,787	\$ 4,496,337	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 377,149	\$ 377,149	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	175,682	175,682	28
29	Short-Term Notes Payable	695,000	695,000	29
30	Accrued Salaries Payable	274,287	274,287	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,850	29,850	31
32	Accrued Real Estate Taxes(Sch.IX-B)		101,000	32
33	Accrued Interest Payable		30,416	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,551,968	\$ 1,683,384	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		10,328,975	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,328,975	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,551,968	\$ 12,012,359	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,198,819	\$ (7,516,022)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,750,787	\$ 4,496,337	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 817,679	1
2	Restatements (describe):		2
3	<u>Rounding</u>	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 817,682	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	562,037	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	(180,900)	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)	\$ 381,137	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)	\$ 1,198,819	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 8,180,600	1
2	Discounts and Allowances for all Levels	(312,996)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,867,604	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	693,854	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 693,854	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	65,516	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,741	19
20	Radiology and X-Ray	2,490	20
21	Other Medical Services	9,934	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 81,681	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	77,391	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 77,391	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,720,532	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,460,165	31
32	Health Care	3,203,437	32
33	General Administration	2,105,070	33
B. Capital Expense			
34	Ownership	934,759	34
C. Ancillary Expense			
35	Special Cost Centers	343,921	35
36	Provider Participation Fee	111,143	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,158,495	40
41	Income before Income Taxes (line 30 minus line 40)**	562,037	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 562,037	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	2,545	2,750	\$ 112,735	\$ 40.99	1
2	Assistant Director of Nursing	2,634	2,923	97,020	33.19	2
3	Registered Nurses	19,965	20,925	642,806	30.72	3
4	Licensed Practical Nurses	8,139	8,349	203,572	24.38	4
5	CNAs & Orderlies	79,542	80,732	986,031	12.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,385	8,915	168,212	18.87	8
9	Activity Director	1,941	2,086	33,878	16.24	9
10	Activity Assistants	7,783	8,228	73,455	8.93	10
11	Social Service Workers	14,592	15,835	218,625	13.81	11
12	Dietician					12
13	Food Service Supervisor	1,820	2,086	35,629	17.08	13
14	Head Cook	8,279	8,866	83,886	9.46	14
15	Cook Helpers/Assistants	14,978	15,945	133,482	8.37	15
16	Dishwashers					16
17	Maintenance Workers	5,525	5,961	87,570	14.69	17
18	Housekeepers	22,401	24,359	206,916	8.49	18
19	Laundry	9,103	9,632	77,840	8.08	19
20	Administrator	1,841	2,086	79,825	38.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,089	20,146	237,727	11.80	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	4,889	5,213	136,908	26.26	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,663	2,663	10,496	3.94	33
34	TOTAL (lines 1 - 33)	235,114	247,700	\$ 3,626,613 *	\$ 14.64	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	Monthly	\$ 17,010	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	4,368	10-03	37
38	Nurse Consultant	Monthly	43,848	10-03	38
39	Pharmacist Consultant	57	3,443	10-03	39
40	Physical Therapy Consultant	Monthly	23,824	10a-03	40
41	Occupational Therapy Consultant	Monthly	1,725	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	525	10a-03	43
44	Activity Consultant	Monthly	2,400	11-03	44
45	Social Service Consultant	68	3,770	12-03	45
46	Other(specify)				46
47	<u>Food Service Director</u>	Monthly	21,924	1-3	47
48	<u>Psychiatric Director</u>	Monthly	7,200	12-03	48
49	TOTAL (lines 35 - 48)	137	\$ 137,237		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,677	\$ 134,310	10-03	50
51	Licensed Practical Nurses	2,744	107,766	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,421	\$ 242,076		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Jamie Lloyd	Administrator	0%	\$ 79,825	Workers' Compensation Insurance	\$ 78,218	IDPH License Fee	\$ 996	
				Unemployment Compensation Insurance	54,349	Advertising: Employee Recruitment	13,426	
				FICA Taxes	271,371	Health Care Worker Background Check	3,020	
				Employee Health Insurance	54,760	(Indicate # of checks performed <u>302</u>)		
				Employee Meals	31,963	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	8,527	
				401K Matching Contributions	4,420	Licenses & Permits	1,372	
				Employee Benefits- Other	11,903	Advertising	25,655	
						Alloc. - SIR Management	297	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,825			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(14,108)	
Description			Amount			Yellow page advertising	(11,547)	
SIR Management - Ancillary Administrative Charges			\$ 45,072					
SIR Management - Director of Administrative Services			43,848					
SIR Management - Council Fees			10,968					
See Supplemental Schedule			412,634					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 512,522					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners	Unemployment Tax Cnsltg		\$ 2,178				Out-of-State Travel	\$
SIR Management	Dir. of Regulatory Srvcs		21,924					
SIR Management	Bookkeeping		85,248					
Frost, Ruttenberg, & Rothblatt	Accounting Fees		19,200				In-State Travel	
SIR Management	Accounting Fees		38,400					
Pinnacle Consulting	Customer Satisfaction Prg		3,268					
E-Health Data	MDS Software		3,600				Seminar Expense	4,270
LTC Solutions	Software Support		1,600				Alloc. - SIR Management	401
MGMT Network Services	Network Services		550					
Legal Fees	(Adj's on Page 5A)		100,954					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 276,922	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 4,671

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/09

Ending:

12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$14002
- (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? N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,586 Line 10
- (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. N/A
- (9) Are you presently operating under a sublease agreement? X YES 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,143
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. \$ 31,963 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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: N/A
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.