

Facility Name & ID Number Maple Lawn Health Center# 0042424 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	<u>89</u>	Skilled (SNF)	<u>89</u>	<u>32,485</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,585</u>	5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,070</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>1,265</u>	<u>1,911</u>	<u>1,742</u>	<u>4,918</u>	8
9	SNF/PED					9
10	ICF	<u>11,704</u>	<u>10,914</u>		<u>22,618</u>	10
11	ICF/DD					11
12	SC	<u>215</u>	<u>7,519</u>		<u>7,734</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,184</u>	<u>20,344</u>	<u>1,742</u>	<u>35,270</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.89%

D. How many bed-hold days during this year were paid by the Department?

 (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)

NoneF. 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 07/1922

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

YES Date 07/1922 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 13 and days of care provided 1,742Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number

Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	371,886	39,471	-	411,357	-	411,357	-	411,357			1
2	Food Purchase		270,956		270,956	-	270,956	(46,679)	224,277			2
3	Housekeeping	98,496	22,671	-	121,167	-	121,167	-	121,167			3
4	Laundry	83,821	7,228	-	91,049	-	91,049	(1,343)	89,706			4
5	Heat and Other Utilities			146,458	146,458	-	146,458	2,443	148,901			5
6	Maintenance	-	7,356	212,025	219,381	-	219,381	(143,513)	75,868			6
7	Other (specify):*				-		-		-			7
8	TOTAL General Services	554,203	347,682	358,483	1,260,368	-	1,260,368	(189,092)	1,071,276			8
	B. Health Care and Programs											
9	Medical Director	-	-	1,650	1,650	-	1,650	-	1,650			9
10	Nursing and Medical Records	1,602,662	91,204	350,850	2,044,716	-	2,044,716	-	2,044,716			10
10a	Therapy	48,390	2,808	123,698	174,896	-	174,896	-	174,896			10a
11	Activities	93,701	5,627	7,673	107,001	-	107,001	-	107,001			11
12	Social Services	44,255	611	27,741	72,607	-	72,607	(26,834)	45,773			12
13	CNA Training	-	-	-	-	-	-	-	-			13
14	Program Transportation	-	-	-	-	-	-	-	-			14
15	Other (specify):*				-		-		-			15
16	TOTAL Health Care and Programs	1,789,008	100,250	511,612	2,400,870	-	2,400,870	(26,834)	2,374,036			16
	C. General Administration											
17	Administrative	96,893	-	394,673	491,566	-	491,566	(394,673)	96,893			17
18	Directors Fees			-	-	-	-	-	-			18
19	Professional Services			135,789	135,789	(522)	135,267	37,755	173,022			19
20	Dues, Fees, Subscriptions & Promotions			32,525	32,525	-	32,525	(4,538)	27,987			20
21	Clerical & General Office Expenses	39,732	10,155	82,774	132,661	522	133,183	514,006	647,189			21
22	Employee Benefits & Payroll Taxes			543,609	543,609	-	543,609	197,288	740,897			22
23	Inservice Training & Education			851	851	-	851	-	851			23
24	Travel and Seminar			2,894	2,894	-	2,894	-	2,894			24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-			25
26	Insurance-Prop.Liab.Malpractice			90,923	90,923	-	90,923	5,447	96,370			26
27	Other (specify):*				-		-		-			27
28	TOTAL General Administration	136,625	10,155	1,284,038	1,430,818	-	1,430,818	355,285	1,786,103			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,479,836	458,087	2,154,133	5,092,056	-	5,092,056	139,359	5,231,415			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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			192,809	192,809		192,809	36,512	229,321		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			129,684	129,684		129,684	(61,815)	67,869		32
33	Real Estate Taxes			2,734	2,734		2,734	(24)	2,710		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			325,227	325,227		325,227	(25,327)	299,900		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		34,673		34,673		34,673		34,673		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			48,728	48,728		48,728		48,728		42
43	Other (specify):*			73,737	73,737		73,737	(73,737)			43
44	TOTAL Special Cost Centers		34,673	122,465	157,138		157,138	(73,737)	83,401		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,479,836	492,760	2,601,825	5,574,421		5,574,421	40,295	5,614,716		45

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

Facility Name & ID Number Maple Lawn Health Center

0042424

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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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(46,023)	2.2		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	1,155	30.3		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				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				24
25	Fund Raising, Advertising and Promotional	(1,516)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(107,136)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,520)		\$	30

BHF USE ONLY					
48		49		50	
				51	
				52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	193,815		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 193,815		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 40,295		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.

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

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
Maple Lawn Homes, Inc.	100%			Maple Lawn Apartments, Inc.	Eureka	Ret. Housing
				Maple Lawn Total Living Care, Inc.	Eureka	Home Care

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	5 Utilities	\$ 9,000	Maple Lawn Homes, Inc.	100.00%	\$ 11,443	\$ 2,443	1
2	V	6 Maintenance	134,781	Maple Lawn Homes, Inc.	100.00%	1,582	(133,199)	2
3	V	12 Social Services	26,834	Maple Lawn Homes, Inc.	100.00%		(26,834)	3
4	V	19 Professional Service		Maple Lawn Homes, Inc.	100.00%	49,455	49,455	4
5	V	21 Administrative and General	42,984	Maple Lawn Homes, Inc.	100.00%	573,127	530,143	5
6	V	17 Administrative and General	394,673	Maple Lawn Homes, Inc.	100.00%		(394,673)	6
7	V	22 Employee Benefits		Maple Lawn Homes, Inc.	100.00%	197,288	197,288	7
8	V	26 Insurance		Maple Lawn Homes, Inc.	100.00%	5,447	5,447	8
9	V	30 Depreciation		Maple Lawn Homes, Inc.	100.00%	36,238	36,238	9
10	V	32 Interest		Maple Lawn Homes, Inc.	100.00%	123	123	10
11	V	33 Real Estate Tax		Maple Lawn Homes, Inc.	100.00%	1,121	1,121	11
12	V	43 Development	73,737	Maple Lawn Homes, Inc.	100.00%		(73,737)	12
13	V							13
14	Total		\$ 682,009			\$ 875,824	\$ * 193,815	14

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

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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 Lawn Health Center

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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 Maple Lawn Homes, Inc.
 Street Address 700 North Main Street
 City / State / Zip Code Eureka, IL 61530
 Phone Number (309)467-2337
 Fax Number (309)467-9097

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost	6,506,690	3	\$ 13,357	\$ 5,574,421	\$ 11,443	1	
2	6	Maintenance	Accumulated Cost	6,506,690	3	1,846	5,574,421	1,582	2	
3	19	Professional Service	Accumulated Cost	6,506,690	3	57,726	5,574,421	49,455	3	
4	21	Supplies	Accumulated Cost	6,506,690	3	39,561	5,574,421	33,893	4	
5	21	Administrative and General	Accumulated Cost	6,506,690	3	629,416	580,612	539,234	5	
6	22	Employee Benefits	Accumulated Cost	6,506,690	3	230,282	5,574,421	197,288	6	
7	26	Insurance - Prop. Liab.	Accumulated Cost	6,506,690	3	6,358	5,574,421	5,447	7	
8	30	Depreciation	Accumulated Cost	6,506,690	3	42,299	5,574,421	36,238	8	
9	32	Interest	Accumulated Cost	6,506,690	3	143	5,574,421	123	9	
10	33	Real Estate Tax	Accumulated Cost	6,506,690	3	1,309	5,574,421	1,121	10	
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,022,297	\$ 580,612	\$ 875,824	25	

Facility Name & ID Number

Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	FHA Mortgage # 1		X	Building	\$4,663.00	4/4/79	\$ 860,000	\$ 132,087	4/4/11	0.0500	\$ 7,914	1
2	FHA Mortgage # 2		X	Building	\$6,300.00	7/7/89	900,000	416,092	7/7/14	0.0650	28,710	2
3	FHA Mortgage # 5		x	Building	\$1,779.00	Aug-04	400,000	349,453	Aug-34	0.0413	14,678	3
4	City of Eureka Bonds		X	Building	\$3,465.00	7/7/89	455,000	182,543	7/7/12	0.0340	9,648	4
5	FHA Mortgage # 4		X	Building	\$5,500.00	Oct-04	305,000	1,051,388	Oct-34	0.0438	46,463	5
Working Capital												
6	Heartland		X	Line of credit	varies	Apr-04	112,000	463,951	Apr-07	0.0713	22,271	6
7												7
8												8
9	TOTAL Facility Related				\$21,707.00		\$ 3,032,000	\$ 2,595,514			\$ 129,684	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,032,000	\$ 2,595,514			\$ 129,684	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
 B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	2,813	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2,734	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(79)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	2,789	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	2,710	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	2,566	8
	2002	2,589	9
	2003	2,603	10
	2004	2,679	11
	2005	2,734	12

C/Y accrual based on prior year tax paid.			
	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to the Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Maple Lawn Health Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0042424

CONTACT PERSON REGARDING THIS REPORT Garry Guimond

TELEPHONE (309) 467-2337 FAX #: (309) 467-9097

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u>13-12-201-026</u>	<u>Beauty Shop</u>	\$ <u>2,734.00</u>	\$ <u>2,734.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>2,734.00</u>	\$ <u>2,734.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2006 Ending:12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,837 B. General Construction Type: Exterior Brick Frame Brick & Steel Number of Stories TwoC. 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).

Maple Lawn Homes, Inc. - Residential Housing, Administrative & General ServicesMaple Lawn Apartments, Inc. - Retirement HousingMaple Lawn Total Living Care, Inc. - Home CareF. 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
A. Land.					
	1 <u>Health Center</u>	<u>85,000</u>	<u>1965</u>	\$ <u>1,386</u>	1
	2 <u>Health Center</u>	<u>39,000</u>	<u>1969</u>	<u>1,000</u>	2
	3 TOTALS	124,000		\$ 2,386	3

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		Jan-65	Jan-65	\$ 472,000	\$ 7,867	60	\$ 7,867	\$	\$ 329,746	4
5			Jan-74	Jan-74	20,378	408	50	408		13,199	5
6			Jan-80	Jan-80	750,017	16,667	45	16,667		448,283	6
7			Jan-82	Jan-82	7,703		20			7,703	7
8	38		Jan-89	Jan-89	1,459,363	32,431	45	32,430	(1)	567,529	8
		Improvement Type**									
9		Landscaping		Jan-82	1,155		20			1,155	9
10		Trees		Jan-84	1,125		20			1,125	10
11		Trees		Jan-84	1,976		20			1,976	11
12		Landscaping - Front of HC		Jan-92	1,100		10			1,100	12
13		Asphalt Repair		Jan-93	4,058		10			4,058	13
14		Parking Lot Lighting		Jan-95	1,282		10			1,282	14
15		Asphalt Parking Lot		Jan-95	2,528		10			2,528	15
16		ADU Enclosure		Jan-95	4,305		10			4,305	16
17		Parking Blocks (20)		Jan-96	654	60	10	60		654	17
18		Lower Level Renovation		Jan-81	203,080		23			203,080	18
19		Lower Level Renovation		Jan-82	35,963		22			35,963	19
20		Fixture Repairs & Refinish		Jan-83	11,150		10			11,150	20
21		Trellis		Jan-83	1,063		10			1,063	21
22		Loading Dock		Jan-85	1,642		20			1,642	22
23		Deck		Jan-92	2,574		10			2,574	23
24		Room Renovaton		Jan-92	1,067		10			1,067	24
25		Lobby Renovation		Jan-93	32,583		10			32,583	25
26		Central Supply Room		Jan-93	1,697		10			1,697	26
27		ADU Cabinets		Jan-94	1,365	28	12	28		1,365	27
28		Wallpaper		Jan-94	776		8			776	28
29		Wallpaper		Jan-95	1,181		8			1,181	29
30		Wallpaper		Jan-95	194		8			194	30
31		Carpet Room 702		Jan-95	203		8			203	31
32		Wallcovering Admin Office		Jan-95	732		8			732	32
33		Conference Room Wing 2		Jan-95	512		8			512	33
34		Lobby Carpet		Jan-96	19,386	969	10	1,130	161	19,386	34
35		Kitchen Ramp Floorcovering		Jan-96	526		8			526	35
36		Room Renovating		Jan-96	969		8			969	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 Lawn Health Center# 0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Walk in Freezer	Jan-75	\$ 2,853	\$	10	\$	\$	\$ 2,853	37
38	Sprinkler Installation	Jan-76	11,240		20			11,240	38
39	Sprinkler Installation	Jan-77	743		20			743	39
40	Generator	Jan-80	9,500		20			9,500	40
41	Lite Fixture- Lobby	Jan-82	4,634		20			4,634	41
42	Floor Covering Ramps Renovation	Jan-82	1,116		10			1,116	42
43	Kitchen Air Vent	Jan-82	650		20			650	43
44	Exhaust Fan	Jan-84	2,800		20			2,800	44
45	Entrance Load Control	Jan-85	13,672		15			13,672	45
46	Light Fixtures	Jan-85	936		10			936	46
47	Water Softner	Jan-87	699		5			699	47
48	Alarm System	Jan-89	5,473		15			5,473	48
49	Wander Guard System	Jan-90	7,685		8			7,685	49
50	Door Alarms	Jan-90	1,461		8			1,461	50
51	Garbage Disposal	Jan-90	951		10			951	51
52	Air Conditioning Condenser	Jan-90	2,395		15			2,395	52
53	Air Conditioning Unit	Jan-91	3,105	155	20	155		2,406	53
54	Management System (5 Units)	Jan-91	1,163	45	15	45		1,163	54
55	Privacy Curtains	Jan-91	11,200		10			11,200	55
56	Water heater Tanks	Jan-92	12,622	841	15	841		12,480	56
57	Century Whirlpool Tub	Jan-93	3,284	219	15	219		3,011	57
58	Laundry Machine Motor	Jan-93	515		30			515	58
59	Assembly Room Sound System	Jan-93	1,410	94	15	94		1,253	59
60	Wander Guard Door Monitor	Jan-93	1,212		8			1,212	60
61	MTCO Telephone System	Jan-93	12,883		10			12,883	61
62	Paging System	Jan-94	707		3			707	62
63	ADU Door Monitoring System	Jan-94	914		3			914	63
64	Upgrade Elevator	Jan-94	3,298		10			3,298	64
65	Air Conditioning -Dining Room	Jan-94	1,723	29	20	86	57	1,062	65
66	Hatco Toaster	Jan-95	980		10			980	66
67	Fiber Optics Wiring	Jan-95	4,645		5			4,645	67
68	Dining Room A/C Unit	Jan-95	3,187	159	20	159		1,858	68
69	Wood Graphics Signs	Jan-95	1,131		7			1,131	69
70	TOTAL (lines 4 thru 69)		\$ 3,175,094	\$ 59,972		\$ 60,189	\$ 217	\$ 1,828,832	70

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,175,094	\$ 59,972		\$ 60,189	\$ 217	\$ 1,828,832	1
2	Kitchen Shelves / Counter	Jan-95	6,667	444	15	444		4,984	2
3	Parker Bath	Jan-95	8,598		10			8,598	3
4	Magnetic Door Lock System	Jan-96	2,846		10	47	47	2,846	4
5	Service Sink	Jan-96	656	11	10	10	(1)	656	5
6	Nurse Call System	Jan-96	21,777	1,996	10	1,996		21,777	6
7	A/C Unit -Central Supply Room	Jan-96	3,515	117	10	116	(1)	3,515	7
8	Elevator Upgrade	Jan-96	13,117	437	10	437		13,117	8
9	A/C Unit Laundry Room	Jan-96	5,986	200	10	198	(2)	5,986	9
10	A/C Unit Kitchen	Jan-96	5,688	379	10	237	(142)	5,688	10
11	Alarm System	Jan-96	709		8			709	11
12	Tektone Door Alarm	Jan-96	673		8			673	12
13	Vertical Blinds	Jan-94	1,021		8			1,021	13
14	Landscaping	Jan-97	3,116	312	10	312		3,013	14
15	Remodel Smoking Area	Jan-97	553	55	10	55		538	15
16	Patient Room Renovation	Jan-97	979		8			979	16
17	Lobby Renovation	Jan-97	499	5	9	6	1	499	17
18	Sink & Counter for Empl.Lounge	Jan-97	1,319		8			1,319	18
19	Fireplace Conversion	Jan-97	2,762	138	10	276	138	2,669	19
20	Kitchen Waterline Replacement	Jan-97	1,591	159	10	159		1,458	20
21	Chapel Renovation	Jan-97	17,045	1,705	10	1,705		15,342	21
22	Nurse Call System Cords	Jan-97	588		5			588	22
23	Addressable Fire alarm System	Jan-97	11,790	1,179	10	1,179		11,692	23
24	Fire Alarm Annunciator	Jan-97	985	99	10	99		954	24
25	Expansion Tank	Jan-97	3,800		8			3,800	25
26	Door Security Upgrade	Jan-97	2,843		10	284	284	2,747	26
27	Phone System Additions	Jan-97	821	82	10	82		739	27
28	Bathtub	Jan-97	6,080	608	10	608		5,472	28
29	Bath Lift	Jan-97	3,294	329	10	329		2,963	29
30	Parking Lot Repair	Jan-98	1,829	183	10	183		1,494	30
31	Landscaping	Jan-98	700	70	10	70		589	31
32	Boiler Repairs	Jan-98	2,415		10	242	242	2,155	32
33	Automatic Door	Jan-98	3,651	365	10	365		3,164	33
34	TOTAL (lines 1 thru 33)		\$ 3,313,007	\$ 68,845		\$ 69,628	\$ 783	\$ 1,960,576	34

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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 12B, Carried Forward		\$ 3,313,007	\$ 68,845		\$ 69,628	\$ 783	\$ 1,960,576	1
2	Wing 3 Renovation	Jan-98	2,825		10	283	283	2,309	2
3	Dining Room Renovation	Jan-98	13,665		10			13,665	3
4	Hall 3 Fire Detectors	Jan-98	1,794	56	8	57	1	1,794	4
5	Hall 2 Fire Detectors	Jan-98	2,994	125	8	125		2,994	5
6	Emergency Generator Repairs	Jan-98	1,356	136	10	136		1,165	6
7	Free Standing Bath	Jan-98	8,958	896	10	896		7,466	7
8	Security System/ADU Outdoor Gate	Jan-98	1,127	117	8	117		1,127	8
9	Cable System	Jan-98	24,353		5			24,353	9
10	A/C Lower Lobby - By Dining Rm	Jan-98	3,604	360	10	360		2,882	10
11	Asphalt Repair	Jan-99	2,467	247	10	247		1,810	11
12	Dining Room Renovation	Jan-99	1,428		10	143	143	1,108	12
13	Hall 6 Renovation	Jan-99	2,588	259	10	259		1,898	13
14	New Door for Entrance	Jan-99	2,665	267	10	267		1,911	14
15	Hall 7 Renovation	Jan-99	6,647	665	10	665		4,709	15
16	Bath Flooring	Jan-99	2,018	252	8	252		1,786	16
17	Janitor Floor	Jan-99	326	41	8	41		289	17
18	Hall 1 Renovation	Jan-99	2,276		8	285	285	2,017	18
19	Electronic Eye Door-Main Entrance	Jan-99	3,723	372	10	372		2,605	19
20	Office Renovation	Jan-99	2,458	246	10	246		1,721	20
21	Lounge Renovation	Jan-99	927	93	10	93		650	21
22	Door alarms Halls 1 & 3	Jan-99	4,285	536	8	535	(1)	4,285	22
23	Fire Alarms Halls 1,6,7	Jan-99	5,290	661	8	661		5,124	23
24	A/C Condensor	Jan-99	1,001	100	10	100		751	24
25	Adjustable Sink	Jan-99	2,569	321	8	321		2,248	25
26	Carousel Whirlpool	Jan-99	16,897	1,690	10	1,690		11,829	26
27	Heating A/C Unit Hall 6	Jan-99	998		10	100	100	699	27
28	Asphalt Repair	Jan-00	2,352	235	10	235		1,469	28
29	Tempered Water System Redesigned	Jan-00	14,400	720	20	720		4,800	29
30	Renovate Social Service Office	Jan-00	3,422	342	10	342		2,252	30
31	Wanderguard Monitors	Jan-00	2,591	324	8	324		2,173	31
32	New Boiler in Cleveland Steamer	Jan-00	4,076	408	10	408		2,549	32
33	Octel 100 Voicemail System	Jan-00	6,260		5			6,260	33
34	TOTAL (lines 1 thru 33)		\$ 3,465,347	\$ 78,314		\$ 79,908	\$ 1,594	\$ 2,083,274	34

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,465,347	\$ 78,314		\$ 79,908	\$ 1,594	\$ 2,083,274	1
2	Cable System Expansion	Jan-00	1,844		5			1,844	2
3	Land Improve- Sidewalk Replacement	Jan-01	485	48	10	49	1	248	3
4	Water System Installation	Jan-01	41,500	2,075	20	2,075		12,277	4
5	Administrative Office - Carpet	Jan-01	1,447	181	8	181		1,040	5
6	Fire Alarms- Halls 4 & 5	Jan-01	6,436	805	8	805		4,829	6
7	Air Condition Unit Hall 6	Jan-01	3,424	342	10	342		1,911	7
8	Door Alarms - Hall 7	Jan-01	2,757	345	8	345		1,810	8
9	Elevator Safety Edges	Jan-02	3,245	325	10	325		1,489	9
10	Reshingle - Memorial Hall	Jan-02	739	37	20	37		160	10
11	A/C Condensor - HC Lobby	Jan-02	785	79	10	79		348	11
12	Cable System Upgrade	Jan-02	1,138	228	5	228		988	12
13	Sandblasted Redwood Signs	Jan-02	736	105	7	105		429	13
14	Room 601 Construction	Jan-03	34,315	1,716	20	1,716		6,292	14
15	Room 306 Bathroom Conversion	Jan-03	21,425	2,142	10	2,143	1	7,857	15
16	PT Room Divider Curtain	Jan-03	2,589	259	10	259		950	16
17	Crosslink II Traverline Carpet	Jan-03	936	117	8	117		429	17
18	Insinkerator Disposer for Kitchen	Jan-03	1,048	210	5	210		770	18
19	New Exit Doors & Keypads	Jan-03	9,618	1,374	7	1,374		4,580	19
20	New Parking Lot	Jan-03	9,378	782	12	782		2,802	20
21	Wallpaper -Rm 302/Hall#1/Dining Rm	Jan-03	542	77	7	77		276	21
22	Wallpaper Stock for Room Renovations	Jan-03	600		7	86	86	308	22
23	Asbestos removal - Dining Rm Floor	Jan-03	10,520	1,503	7	1,503		5,010	23
24	Vinyl Flooring in Dining Rm	Jan-03	12,700	1,814	7	1,814		6,047	24
25	Wallpaper Hall 2	Feb-04	700	100	7	100		287	25
26	Expansion Dining Room	Feb-04	2,612	174	15	174		499	26
27	Flooring for Elevator	Jul-04	1,479	185	8	185		450	27
28	Walk-in Cooler	Mar-04	8,043	804	10	804		2,245	28
29	Door Lock	Mar-04	3,313	474	7	473	(1)	1,318	29
30	Telephone System	Apr-04	16,115	1,612	10	1,612		4,341	30
31	Draperies	Feb-04	733	105	7	105		303	31
32	Draperies	Apr-04	974	139	7	139		376	32
33	Sealcoat Parking Lot	Sep-04	2,479	826	3	826		1,860	33
34	TOTAL (lines 1 thru 33)		\$ 3,670,002	\$ 97,297		\$ 98,978	\$ 1,681	\$ 2,157,647	34

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,670,002	\$ 97,297		\$ 98,978	\$ 1,681	\$ 2,157,647	1
2	Landscaping	Jul-04	2,778	278	10	278		687	2
3	Renovation on resident rooms, hallways	Jan-05	670,114	22,943	30	22,337	(606)	44,613	3
4	Roof replacement	Jan-05	414,304	13,810	30	13,810		27,582	4
5	Resident room doors and refinishing	Jun-05	6,164	205	30	205		314	5
6	Carpet and Tile Flooring	Jun-05	39,119	2,609	15	2,608	(1)	3,923	6
7	Wallpaper for lobby	Jun-05	3,921	392	10	392		590	7
8	Sprinkler system	Jan-05	71,880	2,396	30	2,396		4,785	8
9	Lighting resident rooms and lobby.	Jun-05	4,754	159	30	158	(1)	242	9
10	Time clock system	Jun-05	34,290	3,429	10	3,429		5,158	10
11	Privacy track, window rods, draperies	Jan-05	5,678	717	7	811	94	1,620	11
12	Carpeting room 608	Mar-05	758	95	8	95		166	12
13	Wiring Upgrade	Jan-05	1,498	300	5	300		578	13
14	A/C condenser replacement	May-05	4,775	318	15	318		505	14
15	Boiler replacement	Apr-05	4,495	449	10	450	1	762	15
16	Asphalt Repairs	Jun-05	1,200	240	5	240		361	16
17	Renovate Multi-Rm/Nurse Station	Jun-05	85,586	2,853	30	2,853		4,291	17
18	Roof Replacement Dietary	Jul-05	14,503	483	30	483		688	18
19	Nurse Station Bumper Guards	Aug-05	491	98	5	98		137	19
20	Chimney roofing work	Aug-05	2,180	109	20	109		145	20
21	Install sink	Sep-05	1,345	90	15	90		113	21
22	Transfer switch	Jun-05	2,549	364	7	364		558	22
23	Sprinkler system	Jun-05	934	31	30	31		47	23
24	Air conditioning unit	Sep-05	3,300	220	15	220		289	24
25	Sprinkler head	Dec-05	1,458	49	30	49		51	25
26	Gas shut-off fire system	Aug-05	2,600	87	30	87		116	26
27	Fire alarm	Oct-05	11,087	739	15	739		891	27
28	Boiler pump	Dec-05	3,986	399	10	399		416	28
29	Door	Oct-06	1,379	23	10	23		23	29
30	Plumbing	Aug-06	1,023	34	10	34		34	30
31	Carpeting	Jan-06	2,618	253	10	240	(13)	240	31
32	Draperies	Feb-06	174	23	7	23		23	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,070,943	\$ 151,492		\$ 152,647	\$ 1,155	\$ 2,257,595	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	Totals from Page 12E, Carried Forward		\$ 5,070,943	\$ 151,492		\$ 152,647	\$ 1,155	\$ 2,257,595	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
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,070,943	\$ 151,492		\$ 152,647	\$ 1,155	\$ 2,257,595	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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 12F, Carried Forward		\$ 5,070,943	\$ 151,492		\$ 152,647	\$ 1,155	\$ 2,257,595	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)		\$ 5,070,943	\$ 151,492		\$ 152,647	\$ 1,155	\$ 2,257,595	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 236,627	\$ 35,408	\$ 35,408	\$	various	\$ 152,304	71
72	Current Year Purchases	13,141	901	901		various	901	72
73	Fully Depreciated Assets	273,504				various	273,504	73
74								74
75	TOTALS	\$ 523,272	\$ 36,309	\$ 36,309	\$		\$ 426,709	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	Patient Transport	2001, Ford van	Mar-05	\$ 9,054	\$ 4,527	\$ 4,527	\$	5	\$ 5,885	76
77										77
78										78
79										79
80	TOTALS			\$ 9,054	\$ 4,527	\$ 4,527	\$		\$ 5,885	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)	\$ 5,605,655	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 192,328	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 193,483	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,155	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,690,189	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	281 Walkway	\$ 21,141	\$ 481	\$ 12,453	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 21,141	\$ 481	\$ 12,453	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 175,000	92
93			93
94			94
95		\$ 175,000	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	_____/2007	\$ _____
13.	_____/2008	\$ _____
14.	_____/2009	\$ _____

* 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

Facility Name & ID Number Maple Lawn Health Center# 0042424 Report Period Beginning:

1/1/2006 Ending:

12/31/2006

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	10a.3	hrs	\$	197	\$ 13,798	\$	197	\$ 13,798	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		230	18,456		230	18,456	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		159	11,994		159	11,994	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescripts				34,673		34,673	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2								13
14	TOTAL			\$	586	\$ 44,248	\$ 34,673	586	\$ 78,921	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.

Facility Name & ID Number Maple Lawn Health Center# 0042424Report Period Beginning: 1/1/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of #####

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 338,276	\$	1
2	Cash-Patient Deposits	11,230		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (58,919))	803,835		3
4	Supply Inventory (priced at <u>FIFO</u>)	50,107		4
5	Short-Term Investments			5
6	Prepaid Insurance	300		6
7	Other Prepaid Expenses	7,007		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	66,082		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,276,837	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	80,498		12
13	Land	2,386		13
14	Buildings, at Historical Cost	4,391,035		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	878,239		16
17	Accumulated Depreciation (book methods)	(2,377,940)		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>Construction in Process</u>	175,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,149,218	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,426,055	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (226,749)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(11,230)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(130,264)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(2,789)		32
33	Accrued Interest Payable	(5,222)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Accrued Expenses</u>	(36,855)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (413,109)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(2,603,752)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,603,752)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (3,016,861)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,409,194)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (4,426,055)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,540,409	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,540,409	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(131,215)	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	()	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)	\$ (131,215)	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)	\$ 1,409,194	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

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		2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,952,143	1
2	Discounts and Allowances for all Levels	(1,426,069)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,526,074	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	447,750	6
7	Oxygen	5,954	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 453,704	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	656	12
13	Barber and Beauty Care	3,845	13
14	Non-Patient Meals	72,330	14
15	Telephone, Television and Radio	13,059	15
16	Rental of Facility Space		16
17	Sale of Drugs	35,425	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,610	19
20	Radiology and X-Ray	189	20
21	Other Medical Services	109,733	21
22	Laundry	1,343	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 240,190	23
	D. Non-Operating Revenue		
24	Contributions	106,186	24
25	Interest and Other Investment Income***	61,938	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 168,124	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Admission Fee	33,001	28
28a	Miscellaneous	22,113	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 55,114	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,443,206	30

1		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,260,368	31
32	Health Care	2,400,870	32
33	General Administration	1,430,818	33
	B. Capital Expense		
34	Ownership	325,227	34
	C. Ancillary Expense		
35	Special Cost Centers	108,410	35
36	Provider Participation Fee	48,728	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,574,421	40
41	Income before Income Taxes (line 30 minus line 40)**	(131,215)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (131,215)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

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	2,104	2,314	\$ 62,986	\$ 27.21	1
2	Assistant Director of Nursing	2,137	2,193	31,745	14.48	2
3	Registered Nurses	5,504	8,256	176,086	21.33	3
4	Licensed Practical Nurses	15,077	16,585	347,739	20.97	4
5	CNAs & Orderlies	53,654	91,212	969,359	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,775	4,153	48,390	11.65	8
9	Activity Director	2,013	2,114	31,653	14.98	9
10	Activity Assistants	3,870	5,805	62,048	10.69	10
11	Social Service Workers	2,036	3,665	44,255	12.08	11
12	Dietician	2,032	2,235	40,344	18.05	12
13	Food Service Supervisor	2,250	2,700	53,763	19.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,099	27,609	277,779	10.06	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	7,840	11,760	120,299	10.23	18
19	Laundry	6,158	6,774	62,018	9.16	19
20	Administrator	1,514	2,080	96,893	46.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,988	5,038	39,732	7.89	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(specify)					32
33	Other(specify) <u>Ward Clerk</u>	1,755	1,790	14,747	8.24	33
34	TOTAL (lines 1 - 33)	141,806	196,282	\$ 2,479,836 *	\$ 12.63	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		\$	1.3	35
36	Medical Director	11	1,650	9.3	36
37	Medical Records Consultant	35	2,095	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	22	1,650	10.3	39
40	Physical Therapy Consultant	30	1,707	10a.3	40
41	Occupational Therapy Consultant	55	2,990	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant			11.3	44
45	Social Service Consultant	13	908	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	166	\$ 11,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	417	\$ 15,720	10.3	50
51	Licensed Practical Nurses	2,910	107,171	10.3	51
52	Certified Nurse Assistants/Aides	10,437	199,309	10.3/10a.3	52
53	TOTAL (lines 50 - 52)	13,764	\$ 322,200		53

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. Life Services Network of IL 4,853
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 6.6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,161 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. \$ 48,728
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. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 46,023
- (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? 100% of Program
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not issued at time of filing cost report.
- (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 \$2500, 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.