

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040428

Facility Name: Maplewood Care

Address: 50 North Jane Drive Elgin 60123
 Number City Zip Code

County: Kane

Telephone Number: (847) 697-3750 **Fax #** (847) 697-5385

HFS ID Number: 363868385001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,076</u>	<u>1,362</u>	<u>1,844</u>	<u>22,282</u>	8
9	SNF/PED					9
10	ICF	<u>42,519</u>	<u>3,177</u>		<u>45,696</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>61,595</u>	<u>4,539</u>	<u>1,844</u>	<u>67,978</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.74%

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

2,150 (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)

N/A

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 4/1/93

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

YES Date 4/1/93 NO

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

YES NO If YES, enter number of beds certified 23 and days of care provided 1,461

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	240,755	33,633	34,174	308,562		308,562	(18,576)	289,986			1
2	Food Purchase		314,785		314,785	(31,733)	283,052	(209)	282,842			2
3	Housekeeping	220,839	44,534		265,373		265,373	816	266,189			3
4	Laundry	28,590	29,966		58,556		58,556	(849)	57,707			4
5	Heat and Other Utilities			170,463	170,463		170,463	2,672	173,135			5
6	Maintenance	70,342	23,434	128,249	222,025		222,025	(18,835)	203,190			6
7	Other (specify):*							4,736	4,736			7
8	TOTAL General Services	560,526	446,352	332,886	1,339,764	(31,733)	1,308,031	(30,245)	1,277,786			8
	B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100		6,100			9
10	Nursing and Medical Records	1,976,144	151,032	190,507	2,317,683		2,317,683	(25,194)	2,292,489			10
10a	Therapy	74,923	8,676	28,632	112,231		112,231	(3,219)	109,012			10a
11	Activities	89,960	12,356	2,352	104,668		104,668		104,668			11
12	Social Services	210,422	129	12,674	223,225		223,225		223,225			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,717	4,717			15
16	TOTAL Health Care and Programs	2,351,449	172,193	240,265	2,763,907		2,763,907	(23,696)	2,740,211			16
	C. General Administration											
17	Administrative	66,242		75,552	141,794		141,794	4,085	145,879			17
18	Directors Fees											18
19	Professional Services			159,329	159,329	(2,437)	156,892	(112,700)	44,192			19
20	Dues, Fees, Subscriptions & Promotions			54,234	54,234		54,234	(34,409)	19,825			20
21	Clerical & General Office Expenses	219,689	25,616	193,668	438,973		438,973	(97,669)	341,304			21
22	Employee Benefits & Payroll Taxes			436,723	436,723	31,733	468,456	(2,663)	465,793			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,428	6,428		6,428	404	6,832			24
25	Other Admin. Staff Transportation			11,654	11,654		11,654	3,318	14,972			25
26	Insurance-Prop.Liab.Malpractice			150,824	150,824		150,824	16,603	167,427			26
27	Other (specify):*							23,818	23,818			27
28	TOTAL General Administration	285,931	25,616	1,088,412	1,399,959	29,296	1,429,255	(199,213)	1,230,042			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,197,906	644,161	1,661,563	5,503,630	(2,437)	5,501,193	(253,155)	5,248,038			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: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			77,643	77,643		77,643	151,639	229,282			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			192,371	192,371		192,371	515,943	708,314			32
33	Real Estate Taxes			98,168	98,168	2,437	100,605	(14,755)	85,850			33
34	Rent-Facility & Grounds			739,300	739,300		739,300	(739,300)				34
35	Rent-Equipment & Vehicles			8,862	8,862		8,862	4,450	13,312			35
36	Other (specify):*							16,588	16,588			36
37	TOTAL Ownership			1,116,344	1,116,344	2,437	1,118,781	(65,435)	1,053,346			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,110	94,647	148,757		148,757		148,757			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		54,110	205,790	259,900		259,900		259,900			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,197,906	698,271	2,983,697	6,879,874		6,879,874	(318,590)	6,561,284			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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning: 01/01/06

Ending: 12/31/06

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				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	131,627	30		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	(209)	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				18
19	Entertainment				19
20	Contributions	(2,605)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(154,476)	21		24
25	Fund Raising, Advertising and Promotional	(10,745)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,258)	20		28
29	Other-Attach Schedule	(1,110)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,776)		\$	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)	(266,813)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (266,813)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (318,590)		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	Exceptional Care Program					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

Mablewood Care, ID# 0040428
 Report Period Beginning: 01/01/06
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
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
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27			27
28			28
29			29
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87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(9,110)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/06

Ending:

12/31/06**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(13,229)	(5,347)						(18,576)	1
2	Food Purchase	(209)											(209)	2
3	Housekeeping			841					(25)				816	3
4	Laundry								(849)				(849)	4
5	Heat and Other Utilities			1,112	1,560								2,672	5
6	Maintenance	(4,500)		1,001	(9,763)		(5,573)						(18,835)	6
7	Other (specify):*				1,041	1,420	2,275						4,736	7
8	TOTAL General Services	(4,709)		2,954	(7,162)	(11,809)	(8,645)		(874)				(30,245)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(19,998)				(5,196)				(25,194)	10
10a	Therapy						(3,219)						(3,219)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,618		1,099						4,717	15
16	TOTAL Health Care and Programs				(16,380)		(2,120)		(5,196)				(23,696)	16
	C. General Administration													
17	Administrative			18,313	(59,819)	49,911	(4,320)						4,085	17
18	Directors Fees													18
19	Professional Services	(3,197)		(109,745)	289	16,393	(16,440)						(112,700)	19
20	Fees, Subscriptions & Promotions	(35,138)		295	434								(34,409)	20
21	Clerical & General Office Expenses	(156,041)		63,681	(5,309)								(97,669)	21
22	Employee Benefits & Payroll Taxes							(2,663)					(2,663)	22
23	Inservice Training & Education													23
24	Travel and Seminar			100	304								404	24
25	Other Admin. Staff Transportation			636	2,682								3,318	25
26	Insurance-Prop.Liab.Malpractice	15,682		350	571								16,603	26
27	Other (specify):*			11,496	4,095	8,227							23,818	27
28	TOTAL General Administration	(178,694)		(14,874)	(56,753)	74,531	(20,760)	(2,663)					(199,213)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(183,403)		(11,920)	(80,295)	62,722	(31,525)	(2,663)	(6,070)				(253,155)	29

STATE OF ILLINOIS

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/06

Ending:

Summary B

12/31/06

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	131,627	15,920	1,799	2,293								151,639	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		516,000	(576)	519								515,943	32
33	Real Estate Taxes		(22,162)	2,587	4,820								(14,755)	33
34	Rent-Facility & Grounds		(739,300)										(739,300)	34
35	Rent-Equipment & Vehicles			2,207	2,243								4,450	35
36	Other (specify):*		16,588										16,588	36
37	TOTAL Ownership	131,627	(212,954)	6,017	9,875								(65,435)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													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													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,776)	(212,954)	(5,903)	(70,420)	62,722	(31,525)	(2,663)	(6,070)				(318,590)	45

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 516,000	Maplewood-Jane LLC		\$	\$ (516,000)	1
2	V	34 Rent-Deposit Amortization	223,300	Maplewood-Jane LLC			(223,300)	2
3	V	33 Real Estate Tax Income	98,158	Maplewood-Jane LLC			(98,158)	3
4	V	36 Amortization		Maplewood-Jane LLC		16,588	16,588	4
5	V	30 Depreciation		Maplewood-Jane LLC		15,920	15,920	5
6	V	32 Interest Expense		Maplewood-Jane LLC		516,000	516,000	6
7	V	33 Real Estate Taxes		Maplewood-Jane LLC		75,996	75,996	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 837,458			\$ 624,504	\$ * (212,954)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/06Ending: 12/31/06

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	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 841	841	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,112	1,112	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,001	1,001	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	18,313	18,313	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,193	1,193	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	295	295	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	63,681	63,681	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	100	100	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	636	636	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	350	350	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	11,496	11,496	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,799	1,799	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(576)	(576)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,587	2,587	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,207	2,207	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	110,938	PREFERRED BOOKKEEPING	100.00%		(110,938)	32
33	V	19 COMPUTER	4,872	PREFERRED BOOKKEEPING	100.00%	4,872		33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 115,810			\$ 109,907	\$ * (5,903)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/06Ending: 12/31/06

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,560	1,560	15
16	V	6 REPAIRS AND MAINT.	18,276	S.I.R. MANAGEMENT, INC.	100.00%	8,513	(9,763)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,041	1,041	17
18	V	10 NURSING	40,200	S.I.R. MANAGEMENT, INC.	100.00%	20,202	(19,998)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,618	3,618	19
20	V	17 ADMINISTRATIVE	71,232	S.I.R. MANAGEMENT, INC.	100.00%	11,413	(59,819)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	289	289	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	434	434	22
23	V	21 CLERICAL & GENERAL	20,712	S.I.R. MANAGEMENT, INC.	100.00%	15,403	(5,309)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	304	304	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,682	2,682	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	571	571	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,095	4,095	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,293	2,293	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	519	519	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,820	4,820	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,243	2,243	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 150,420			\$ 80,000	\$ * (70,420)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/06Ending: 12/31/06

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	\$ 20,712	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,483	(13,229)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,420	1,420	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	49,911	49,911	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	16,393	16,393	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,227	8,227	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 20,712				\$ 83,434	\$ * 62,722	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/06Ending: 12/31/06

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	10A SPECIAL REHAB	9,012	S.I.R. MANAGEMENT, INC.	100.00%	5,793	\$	(3,219)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,099		1,099	16
17	V								17
18	V	6 REPAIRS AND MAINT.	14,112	S.I.R. MANAGEMENT, INC.	100.00%	8,539		(5,573)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,620		1,620	19
20	V								20
21	V								21
22	V	1 DIETICIAN SALARIES	8,800	S.I.R. MANAGEMENT, INC.	100.00%	3,453		(5,347)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	655		655	23
24	V								24
25	V	19 LEGAL FEES	16,440	S.I.R. MANAGEMENT, INC.	100.00%			(16,440)	25
26	V								26
27	V	17 COUNCIL DUES	4,320	S.I.R. MANAGEMENT, INC.	100.00%			(4,320)	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		\$ 52,684			\$ 21,159	\$ *	(31,525)	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	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 131,536	\$ 131,536	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	134,199	CCS EMPLOYEE BENEFIT GROUP	100.00%		(134,199)	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			\$ 134,199			\$ 131,536	\$ * (2,663)	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	01 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	03 Housekeeping	309	Xcel Supply, LLC	100.00%	284	(25)	16
17	V	04 Laundry	10,463	Xcel Supply, LLC	100.00%	9,615	(849)	17
18	V	06 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	64,076	Xcel Supply, LLC	100.00%	58,879	(5,196)	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, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office		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		\$ 74,848			\$ 68,778	\$ * (6,070)	39

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

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning: 01/01/06

Ending: 12/31/06

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.

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			\$			\$		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.

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			\$			\$		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: 01/01/06 Ending: 12/31/06

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	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.77	1.67%	Alloc. Salary	\$ 10,426	17-7	1
2	Nenita Guzman	Relative	Dietary	0.00%	See Attached	5.46	10.92%	Alloc. Salary	7,483	1-7	2
3	Louise Bergthold	Shareholder	Administrative	6.09%	See Attached	6.01	10.93%	Alloc. Salary	18,034	17-7	3
4	Tom Winter	Shareholder	Administrative	0.77%	See Attached	6.66	11.10%	Alloc. Salary	18,313	17-7	4
5	Jeff Oravec	Shareholder	Administrative	0.51%	See Attached	4.37	10.93%	Alloc. Salary	11,146	17-7	5
6	Joey Abramchick	Shareholder	Administrative	2.54%	See Attached	4.92	10.93%	Alloc. Salary	16,393	17-7	6
7	Stuart Sikes	Shareholder	Administrative	1.02%	See Attached	4.37	10.93%	Alloc. Salary	11,636	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 93,431		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: 01/01/06 Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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 PREFERRED BOOKKEEPING SERVICES
 Street Address 4100 WEST PRATT AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 674-5200
 Fax Number (847) 674-5267

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	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 999,524	10	\$ 7,576	\$	110,938	\$ 841	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 999,524	10	10,021		110,938	1,112	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 999,524	10	9,017		110,938	1,001	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 999,524	10	165,000	165,000	110,938	18,313	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 999,524	10	10,747		110,938	1,193	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 999,524	10	2,655		110,938	295	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 999,524	10	573,753	512,109	110,938	63,681	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 999,524	10	898		110,938	100	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 999,524	10	5,727		110,938	636	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 999,524	10	3,157		110,938	350	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 999,524	10	103,576		110,938	11,496	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 999,524	10	16,212		110,938	1,799	12
13	32	INTEREST	BOOK./ACCNT.INCOME 999,524	10	(5,190)		110,938	(576)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 999,524	10	23,306		110,938	2,587	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 999,524	10	19,888		110,938	2,207	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					4,872	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 946,343	\$ 677,109		\$ 109,907	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	5	UTILITIES	PATIENT DAYS	621,946	10	\$ 14,269	\$ 67,978	\$ 1,560	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	621,946	10	77,891	51,158	67,978	8,513	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	621,946	10	9,520	67,978	1,041	3	
4	10	NURSING	PATIENT DAYS	621,946	10	184,832	184,832	67,978	20,202	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	621,946	10	33,100	67,978	3,618	5	
6	17	ADMINISTRATIVE	PATIENT DAYS	621,946	10	104,417	104,417	67,978	11,413	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	621,946	10	2,646	67,978	289	7	
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	621,946	10	3,970	67,978	434	8	
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	621,946	10	163,095	125,172	67,978	15,403	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	621,946	10	2,778	67,978	304	10	
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	621,946	10	24,542	67,978	2,682	11	
12	26	INSURANCE	PATIENT DAYS	621,946	10	5,228	67,978	571	12	
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	621,946	10	41,464	67,978	4,095	13	
14	30	DEPRECIATION	PATIENT DAYS	621,946	10	20,978	67,978	2,293	14	
15	32	INTEREST	PATIENT DAYS	621,946	10	4,752	67,978	519	15	
16	33	REAL ESTATE TAXES	PATIENT DAYS	621,946	10	44,103	67,978	4,820	16	
17	35	EQUIPMENT RENTAL	PATIENT DAYS	621,946	10	20,518	67,978	2,243	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 758,103	\$ 465,579	\$ 80,000	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	621,946	10	\$ 68,465	\$ 67,978	\$ 7,483	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	621,946	10	12,992	67,978	1,420	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	621,946	10	456,644	456,644	49,911	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	621,946	10	149,980	67,978	16,393	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	621,946	10	75,273	67,978	8,227	5
6									6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	15,163	15,163		7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	376			8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,125			9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	330			10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	25,952			11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,250			12
13									13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	9,863	9,863		14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	375			15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	614			16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	25,440			17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	4,656			18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 852,498	\$ 550,135	\$ 83,434	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 69,259	\$ 69,259	9,012	\$ 5,793	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,143		9,012	1,099	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	126,720	10	76,680	76,680	14,112	8,539	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	126,720	10	14,551		14,112	1,620	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	83,600	10	32,808	32,808	8,800	3,453	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	83,600	10	6,226		8,800	655	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					\$ 212,667	\$ 178,747		\$ 21,159	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 MAIN ST.
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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		\$	\$		131,536	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				\$	\$		131,536	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 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

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	01	Dietary	Direct Allocation		\$	\$		\$	1
2	03	Housekeeping	Direct Allocation					284	2
3	04	Laundry	Direct Allocation					9,615	3
4	06	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					58,879	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees, Subscriptions & Prom	Direct Allocation						8
9	21	Clerical & General Office	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				\$	\$		\$	68,778

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428 Report Period Beginning: 01/01/06 Ending: 12/31/06

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: 01/01/06 Ending: 12/31/06

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: 01/01/06 Ending: 12/31/06

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

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										1										
2										2										
3										3										
4										4										
5	See Supplemental Schedule								516,000	5										
Working Capital																				
6	Lake Forest Bank		X	Working Capital		6/2003		2,735,000	Prime	192,371	6									
7										7										
8	See Supplemental Schedule								(57)	8										
9	TOTAL Facility Related							\$ 2,735,000		\$ 708,314	9									
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13	See Supplemental Schedule									13										
14	TOTAL Non-Facility Related							\$		\$	14									
15	TOTALS (line 9+line14)							\$ 2,735,000		\$ 708,314	15									

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

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:

01/01/06

Ending:

12/31/06

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	Alloc.-Maplewood Care		X				\$	\$			\$ 516,000	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term										516,000	7								
	Working Capital																			
8	Alloc. - Preferred Bookkeeping		X				\$	\$			(576)	8								
9	Alloc. - S.I.R. Management		X								519	9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital										(57)	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.)

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

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 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 Maplewood Care COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040428

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-15-304-015</u>	<u>Long Term Care Property</u>	\$ <u>91,366.00</u>	\$ <u>91,366.00</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>89,494.10</u>	\$ <u>6,948.67</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>180,860.10</u>	\$ <u>98,314.67</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? X YES _____ 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Maplewood Care COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040428

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>_____</u>	\$ <u>_____</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 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Maplewood Care

0040428 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

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

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>262,479</u>	1
2					2
3	TOTALS			\$ 262,479	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Maplewood Care**

0040428

Report Period Beginning:

01/01/06

Ending:

12/31/06

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1993	98,204		20	4,910	4,910	52,668	9
10	Various			1994	13,684		20	684	684	9,154	10
11	Various			1995	5,179		20	259	259	2,969	11
12	Various			1996	19,800		20	990	990	10,725	12
13	Various			1997	21,688		20	1,084	1,084	10,680	13
14	Various			1998	19,077		20	954	954	7,905	14
15	Various			1999	47,028		20	2,351	2,351	16,349	15
16	Various			2000	565,082		20	28,254	28,254	192,652	16
17	Various			2001	72,848		20	3,642	3,642	24,007	17
18	Various			2002	15,524		20	776	776	5,595	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

*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:

01/01/06

Ending:

12/31/06

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		5,445,306	15,920		155,580	139,660	2,096,724	67
68		90,552	3,084		3,559	475	41,133	68
69			20,036			(20,036)		69
70		\$ 6,413,972	\$ 39,040		\$ 203,045	\$ 164,005	\$ 2,470,563	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

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		\$ 6,413,972	\$ 39,040		\$ 203,045	\$ 164,005	\$ 2,470,563	1
2	Stair Rails	2003	2,000		20	100	100	400	2
3	Heat Exchange	2003	2,276		20	114	114	455	3
4	Walk-In Cooler Work	2003	2,673		20	134	134	502	4
5	Sprinkler System	2003	6,975		20	349	349	1,308	5
6	Sealcoating Parking Lot	2003	3,300		20	165	165	550	6
7	Vinyl Tile	2003	930		20	47	47	156	7
8	Hvac Register	2003	1,000		20	50	50	163	8
9	Furnace Ignitor, Flame Sensor	2003	1,116		20	56	56	177	9
10	Hvac Ignition, High Limit Control	2003	1,026		20	51	51	162	10
11	Hvac Fan Delay Timer, Etc	2003	1,053		20	53	53	163	11
12	Elevator Work	2004	1,334		20	67	67	200	12
13	Plumbing	2004	4,952		20	248	248	558	13
14	Steel Door	2004	3,900		20	195	195	650	14
15	Blinds	2004	423		20	21	21	53	15
16	Verticle Rod Panel Bar	2004	584		20	29	29	63	16
17	Vinyl Blinds	2004	628		20	31	31	68	17
18	Tile Repair	2004	801		20	40	40	83	18
19	Compressor	2004	1,558		20	78	78	195	19
20	Condensor Fan Motors	2004	2,119		20	106	106	256	20
21	Fire Sprinkler Repair	2004	1,789		20	89	89	260	21
22	Tile Shower Room	2005	13,597		20	680	680	1,133	22
23	Plumbing	2005	6,542		20	327	327	518	23
24	Call System	2005	8,689		20	434	434	832	24
25	Fire Alarm System	2005	31,622		20	1,581	1,581	2,372	25
26	Fire Alarm / Elevator	2005	4,950		20	248	248	372	26
27	Wall Repair	2005	11,575		20	579	579	772	27
28	Fire Alarm System	2005	3,585		20	179	179	194	28
29	Water Heater	2005	7,708		20	385	385	417	29
30	Heat Exchanger	2005	3,854		20	193	193	225	30
31	Replaced Furnace Burners, Support Plate	2005	1,767		20	88	88	176	31
32	Repaired Furnace Filter Rack	2005	1,506		20	75	75	150	32
33	Replaced Furnace Defective Parts	2005	1,616		20	81	81	162	33
34	TOTAL (lines 1 thru 33)		\$ 6,551,420	\$ 39,040		\$ 209,917	\$ 170,877	\$ 2,484,307	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

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		\$ 6,551,420	\$ 39,040		\$ 209,917	\$ 170,877	\$ 2,484,307	1
2	Install New Vinyl Tile	2005	1,684		20	84	84	168	2
3	Replaced 20 Water Stop Valves	2005	2,064		20	103	103	206	3
4	Replaced 35 Stop Valves For Sinks And Toilets	2005	3,153		20	158	158	316	4
5	Replaced 20 Water Stop Valves	2005	2,663		20	133	133	266	5
6	Curtains	2005	2,505		20	125	125	250	6
7	Hvac -Installed Parts	2005	1,855		20	93	93	186	7
8	Replaced Defective Sink Faucets	2005	2,151		20	108	108	216	8
9	Hvac - Replacement Parts	2005	1,691		20	85	85	170	9
10	Sidewalk	2006	4,500		20	206	206	206	10
11	Roof	2006	246,800		20	6,170	6,170	6,170	11
12	Bathroom Work	2006	12,700		20	582	582	582	12
13	Plumbing Work	2006	2,655		20	122	122	122	13
14	Bathroom Work	2006	11,675		20	195	195	195	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)		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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

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		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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:

01/01/06

Ending:

12/31/06

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 12D, Carried Forward	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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
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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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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:

01/01/06

Ending:

12/31/06

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		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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

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	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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

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 12G, Carried Forward	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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

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 12H, Carried Forward	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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
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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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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:

01/01/06

Ending:

12/31/06

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		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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

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 12J, Carried Forward	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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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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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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:

01/01/06

Ending:

12/31/06

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		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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:

01/01/06

Ending:

12/31/06

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 12L, Carried Forward	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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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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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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:

01/01/06

Ending:

12/31/06

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 12M, Carried Forward		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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
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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)		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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

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 12N, Carried Forward	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359		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

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 12O, Carried Forward		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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)		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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

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		\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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)	\$ 6,847,516	\$ 39,040		\$ 218,080	\$ 179,040	\$ 2,493,359	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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	203		1993	1972	\$ 5,445,306	\$ 15,920	35	\$ 155,580	\$ 139,660	\$ 2,096,724	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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
35											35
36											36

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

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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 5,445,306	\$ 15,920		\$ 155,580	\$ 139,660	\$ 2,096,724	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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	SIR - SIR		1993	1993	\$ 29,206	\$ 927	35	\$ 834	\$ (93)	\$ 11,265	4
5	SIR - PREF		1993	1993	15,673	498	35	448	(50)	6,045	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation			1997	19,573	438	20	979	541	9,599	9
10	Preferred Bookkeeping - Allocation			1999	155	-	20	8	8	58	10
11	Preferred Bookkeeping - Allocation			2000	982	-	20	48	48	315	11
12											
13	S.I.R. Properties - Preferred Bookkeeping - Allocation			2002	62	-	20	3	3	14	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation			1999	1,986	199	20	99	(100)	745	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation			1998	949	95	20	47	(48)	403	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation			1997	59	6	20	3	(3)	31	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation			1994	149	4	20	7	3	93	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation			1993	254	1	20	14	13	172	18
19											
20	S.I.R. Properties - S.I.R. Management - Allocation			2002	116	-	20	6	6	26	20
21	S.I.R. Properties - S.I.R. Management - Allocation			1999	3,701	370	20	185	(185)	1,388	21
22	S.I.R. Properties - S.I.R. Management - Allocation			1998	1,769	177	20	88	(89)	752	22
23	S.I.R. Properties - S.I.R. Management - Allocation			1997	110	11	20	6	(5)	58	23
24	S.I.R. Properties - S.I.R. Management - Allocation			1994	278	7	20	14	7	174	24
25	S.I.R. Properties - S.I.R. Management - Allocation			1993	474	2	20	24	22	320	25
26											
27	S.I.R. Management - Allocation			1993	12,544	349	20	622	273	8,706	27
28	S.I.R. Management - Allocation			1994	39	-	20	-		39	28
29	S.I.R. Management - Allocation			1995	287	-	20	14	14	164	29
30	S.I.R. Management - Allocation			1999	1,363	-	20	68	68	491	30
31	S.I.R. Management - Allocation			2000	823	-	20	42	42	275	31
32											
33											
34											
35											
36											

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

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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		90,552	3,084		3,559	475	41,133	

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: 01/01/06 Ending: 12/31/06

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	\$ 139,981	\$ 12,138	\$ 9,265	\$ (2,874)	10	\$ 80,413	71
72	Current Year Purchases	30,479	46,477	1,937	(44,540)	10	1,937	72
73	Fully Depreciated Assets	42				10	42	73
74								74
75	TOTALS	\$ 170,502	\$ 58,615	\$ 11,202	\$ (47,414)		\$ 82,392	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)	\$ 7,280,497	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,655	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,282	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 131,627	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,575,751	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

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	\$ _____

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: \$ 9,232 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	\$ 4,080	17
18					18
19					19
20					20
21	TOTAL		\$ 339.97	\$ 4,080	21

* 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 62,755	\$		\$ 62,755	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			125			125	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			31,143			31,143	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 prescripts				39,013		39,013	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					2,077		2,077	12
13	Other (specify): <u>See Supplemental</u>					624	13,020		13,644	13
14	TOTAL			\$		\$ 94,647	\$ 54,110		\$ 148,757	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: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 20,147	\$ 20,148	1
2	Cash-Patient Deposits	52,893	52,893	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,646,556	1,646,556	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,887	47,887	6
7	Other Prepaid Expenses	2,865	2,865	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>		101,330	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,770,348	\$ 1,871,679	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	849,920	849,920	15
16	Equipment, at Historical Cost	912,514	1,521,514	16
17	Accumulated Depreciation (book methods)	(934,408)	(3,640,132)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		16,663	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>	488,403	513,207	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,316,429	\$ 2,297,047	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,086,777	\$ 4,168,726	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 204,928	\$ 204,928	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,151	56,151	28
29	Short-Term Notes Payable	2,735,000	2,735,000	29
30	Accrued Salaries Payable	223,422	223,422	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,212	24,212	31
32	Accrued Real Estate Taxes(Sch.IX-B)		95,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	11,378	3,756,253	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,255,091	\$ 7,094,966	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,255,091	\$ 7,094,966	46
47	TOTAL EQUITY (page 18, line 24)	\$ (168,314)	\$ (2,926,240)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,086,777	\$ 4,168,726	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (437,880)	1
2	Restatements (describe):		2
3	Rounding Adjustment	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (437,877)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	269,563	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)	\$ 269,563	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)	\$ (168,314)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 6,801,853	1
2	Discounts and Allowances for all Levels	(41,950)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,759,903	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	251,460	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 251,460	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	37,313	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,707	19
20	Radiology and X-Ray	3,003	20
21	Other Medical Services	15,378	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,401	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	78,673	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 78,673	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,149,437	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,339,764	31
32	Health Care	2,763,907	32
33	General Administration	1,399,959	33
B. Capital Expense			
34	Ownership	1,116,344	34
C. Ancillary Expense			
35	Special Cost Centers	148,757	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)*	\$ 6,879,874	40
41	Income before Income Taxes (line 30 minus line 40)**	269,563	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 269,563	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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:

01/01/06

Ending:

12/31/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,102	2,295	\$ 77,738	\$ 33.87	1
2	Assistant Director of Nursing	4,584	4,827	133,997	27.76	2
3	Registered Nurses	28,717	30,555	843,549	27.61	3
4	Licensed Practical Nurses	209	303	6,774	22.36	4
5	CNAs & Orderlies	61,882	63,025	810,448	12.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,851	7,217	74,923	10.38	8
9	Activity Director	1,917	2,086	30,871	14.80	9
10	Activity Assistants	6,982	7,360	59,089	8.03	10
11	Social Service Workers	14,807	15,877	198,150	12.48	11
12	Dietician					12
13	Food Service Supervisor	1,829	2,086	46,254	22.17	13
14	Head Cook	1,113	1,128	9,065	8.04	14
15	Cook Helpers/Assistants	22,820	24,720	185,436	7.50	15
16	Dishwashers					16
17	Maintenance Workers	4,977	5,327	70,342	13.20	17
18	Housekeepers	29,249	30,637	220,839	7.21	18
19	Laundry	3,831	4,210	28,590	6.79	19
20	Administrator	1,861	2,086	66,242	31.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,088	18,217	219,689	12.06	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	4,389	4,692	103,638	22.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,776	3,776	12,272	3.25	33
34	TOTAL (lines 1 - 33)	218,984	230,424	\$ 3,197,906 *	\$ 13.88	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	\$ 13,462	01-03	35
36	Medical Director	Monthly	6,100	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	40,200	10-03	38
39	Pharmacist Consultant	58	3,500	10-03	39
40	Physical Therapy Consultant	Monthly	15,597	10a-03	40
41	Occupational Therapy Consultant	Monthly	12,990	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	45	10a-03	43
44	Activity Consultant	Monthly	2,352	11-03	44
45	Social Service Consultant	100	5,474	12-03	45
46	Other(specify)				46
47	Psychiatric Director	Monthly	7,200	10-03	47
48	Food Service Director	Monthly	20,712	01-03	48
49	TOTAL (lines 35 - 48)	159	\$ 131,856		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,833	\$ 126,670	10-03	50
51	Licensed Practical Nurses	380	15,913	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,213	\$ 142,583		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

0040428

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 66,242	Workers' Compensation Insurance	\$ 59,722	IDPH License Fee	\$ 994		
				Unemployment Compensation Insurance	40,985	Advertising: Employee Recruitment	4,137		
				FICA Taxes	239,572	Health Care Worker Background Check	2,040		
				Employee Health Insurance	84,277	(Indicate # of checks performed <u>170</u>)			
				Employee Meals	31,733	Patient Background Checks	158 1,900		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Permits	3,183		
				401K Contributions	6,729	Dues	6,842		
				Empolyee Benefits-Other	2,775	Alloc. - Preferred Bookkeeping	295		
						Alloc. - S.I.R. Management	434		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 66,242	TOTAL (agree to Schedule V, line 22, col.8)			\$ 465,793		
B. Administrative - Other								TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount						
SIR Management - Ancillary Administrative Fees			\$ 45,648				Less: Public Relations Expense ()		
SIR Management - Director of Administrative Services			25,584				Non-allowable advertising ()		
SIR Management - Council Fees			4,320				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 75,552						
(Attach a copy of any management service agreement)									
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 Cons		\$ 1,267				Out-of-State Travel	\$	
Preferred Bookkeeping	Accounting Fees		30,550						
FR&R	Accounting Fees		15,355						
e-Health Data	MDS Software		3,465				In-State Travel		
LTC Solutions	Software Support		1,320						
ICS Solutions	Website		38						
Preferred Bookkeeping	Bookkeeping Services		80,388				Seminar Expense	6,428	
SIR Management	Director of Regulatory Svc		16,440				Alloc. - Preferred Bookkeeping	100	
Preferred Bookkeeping	Computer Services		4,872				Alloc. - S.I.R. Management	304	
Adjusted Out Page 5	Legal		3,197						
Raiff Shram	Real Estate Tax Appeal		2,437				Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 159,329	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)								\$ 6,832	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Maplewood Care

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 - \$8183.00
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,557 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.

- (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. \$ 31,733 Has any meal income been offset against related costs? N/A 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? _____
- 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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.

SEE ACCOUNTANTS' COMPILATION REPORT