

		FOR BHF USE				

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2007
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT FOR
 LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2007)

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.

<p>I. IDPH License ID Number: <u>0042424</u></p> <p>Facility Name: <u>Maple Lawn Health Center</u></p> <p>Address: <u>700 North Main Street</u> <u>Eureka</u> <u>61530</u> <small>Number City Zip Code</small></p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 467-2337</u> Fax # <u>(309) 467-9097</u></p> <p>HFS ID Number: <u>37-0681536001</u></p> <p>Date of Initial License for Current Owners: <u>01-Jul-22</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501 (c) 3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Garry Guimond</u> Telephone Number: <u>(309) 467-2337</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/07</u> to <u>12/31/07</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Garry Guimond</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Financial Controller</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="center"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Garry Guimond</u>		(Title) <u>Financial Controller</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Firm Name & Address) _____																																						
	(Telephone) () _____ Fax # () _____																																						

Facility Name & ID Number Maple Lawn Health Center# 0042424 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>89</u>	Skilled (SNF)	<u>89</u>	<u>32,485</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,585</u>	5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,070</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
8	SNF	<u>2,352</u>	<u>1,662</u>	<u>1,916</u>	<u>5,930</u>	8
9	SNF/PED					9
10	ICF	<u>10,903</u>	<u>8,534</u>		<u>19,437</u>	10
11	ICF/DD					11
12	SC	<u>697</u>	<u>5,943</u>		<u>6,640</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,952</u>	<u>16,139</u>	<u>1,916</u>	<u>32,007</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.31%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None _____

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 07/1922

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/1922 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 13 and days of care provided 1,916

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

STATE OF ILLINOIS

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Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	308,664	30,934		339,598		339,598		339,598		1
2	Food Purchase		275,914		275,914		275,914	(71,658)	204,256		2
3	Housekeeping	61,422	17,710		79,132		79,132		79,132		3
4	Laundry	60,929	9,594		70,523		70,523	(437)	70,086		4
5	Heat and Other Utilities			141,215	141,215		141,215	9,185	150,400		5
6	Maintenance	81,295	4,550	89,099	174,944		174,944	(8,867)	166,077		6
7	Other (specify):*										7
8	TOTAL General Services	512,310	338,702	230,314	1,081,326		1,081,326	(71,777)	1,009,549		8
	B. Health Care and Programs										
9	Medical Director			5,150	5,150		5,150		5,150		9
10	Nursing and Medical Records	1,357,967	100,895	208,233	1,667,095		1,667,095		1,667,095		10
10a	Therapy	25,567	2,293	132,483	160,343		160,343		160,343		10a
11	Activities	55,216	5,613	462	61,291		61,291		61,291		11
12	Social Services	56,847	1,532		58,379		58,379		58,379		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,495,597	110,333	346,328	1,952,258		1,952,258		1,952,258		16
	C. General Administration										
17	Administrative	72,872		295,399	368,271		368,271	(295,399)	72,872		17
18	Directors Fees										18
19	Professional Services			162,926	162,926	(545)	162,381	44,039	206,420		19
20	Dues, Fees, Subscriptions & Promotions			53,594	53,594		53,594	(8,918)	44,676		20
21	Clerical & General Office Expenses	50,784	8,183	25,599	84,566	545	85,111	322,087	407,198		21
22	Employee Benefits & Payroll Taxes			406,463	406,463		406,463	83,818	490,281		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,906	7,906		7,906		7,906		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			86,174	86,174		86,174	2,280	88,454		26
27	Other (specify):*										27
28	TOTAL General Administration	123,656	8,183	1,038,061	1,169,900		1,169,900	147,907	1,317,807		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,131,563	457,218	1,614,703	4,203,484		4,203,484	76,130	4,279,614		29

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

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

STATE OF ILLINOIS

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Facility Name & ID Number Maple Lawn Health Center #0042424 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			180,803	180,803		180,803	33,201	214,004			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144,555	144,555		144,555	(4,378)	140,177			32
33	Real Estate Taxes			2,734	2,734		2,734	13	2,747			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			328,092	328,092		328,092	28,836	356,928			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,654		42,654		42,654		42,654			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,728	48,728		48,728		48,728			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		42,654	48,728	91,382		91,382		91,382			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,131,563	499,872	1,991,523	4,622,958		4,622,958	104,966	4,727,924			45

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(71,658)	2.2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(440)	30.3		9
10 Interest and Other Investment Income	(4,460)	32.3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising	(2,198)	20.3		28
29 Other-Attach Schedule	183,722			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (97,719)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	202,685		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 202,685		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 104,966		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
1	V	5	<u>Utilities</u>	\$	<u>Maple Lawn Homes, Inc.</u>	100.00%	\$ 9,185	\$ 9,185	1
2	V	6	<u>Maintenance</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	673	673	2
3	V	12			<u>Maple Lawn Homes, Inc.</u>	100.00%			3
4	V	19	<u>Professional Service</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	44,039	44,039	4
5	V	21	<u>Administrative and General</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	322,518	322,518	5
6	V	17	<u>Administrative and General</u>	295,399	<u>Maple Lawn Homes, Inc.</u>	100.00%		(295,399)	6
7	V	22	<u>Employee Benefits</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	83,818	83,818	7
8	V	26	<u>Insurance</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	2,280	2,280	8
9	V	30	<u>Depreciation</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	34,642	34,642	9
10	V	32	<u>Interest</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	82	82	10
11	V	33	<u>Real Estate Tax</u>		<u>Maple Lawn Homes, Inc.</u>	100.00%	846	846	11
12	V	43			<u>Maple Lawn Homes, Inc.</u>	100.00%			12
13	V								13
14	Total			\$ 295,399			\$ 498,083	\$ * 202,685	14

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	Accumulated Cost	5,396,427	3	\$ 10,722	\$ 4,622,958	\$ 9,185	1	
2	6	Maintenance	Accumulated Cost	5,396,427	3	786	4,622,958	673	2	
3	19	Professional Service	Accumulated Cost	5,396,427	3	51,407	4,622,958	44,039	3	
4	21	Supplies	Accumulated Cost	5,396,427	3	10,702	4,622,958	9,168	4	
5	21	Administrative and General	Accumulated Cost	5,396,427	3	365,777	345,611	4,622,958	313,350	5
6	22	Employee Benefits	Accumulated Cost	5,396,427	3	97,842	4,622,958	83,818	6	
7	26	Insurance - Prop. Liab.	Accumulated Cost	5,396,427	3	2,662	4,622,958	2,280	7	
8	30	Depreciation	Accumulated Cost	5,396,427	3	40,438	4,622,958	34,642	8	
9	32	Interest	Accumulated Cost	5,396,427	3	96	4,622,958	82	9	
10	33	Real Estate Tax	Accumulated Cost	5,396,427	3	988	4,622,958	846	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					\$ 581,420	\$ 345,611	\$ 498,083	25	

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	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	FHA Mortgage # 1		X	Building	4,663.00	4/4/79	\$ 860,000	\$ 81,591	4/4/11	0.0500	\$ 5,456	1
2	FHA Mortgage # 2		X	Building	6,300.00	7/7/89	900,000	367,114	7/7/14	0.0650	26,621	2
3	FHA Mortgage # 5		x	Building	1,779.00	08/01/04	400,000	342,386	08/01/34	0.0413	14,282	3
4	City of Eureka Bonds		X	Building	3,465.00	7/7/89	455,000	154,133	7/7/12	0.0340	8,101	4
5	FHA Mortgage # 4		X	Building	5,500.00	10/18/04	305,000	1,030,979	10/18/34	0.0438	48,106	5
	Working Capital											
6	Heartland		X	Line of credit	varies	04/29/04	112,000	538,936	04/29/08	0.0713	41,989	6
7					-					-		7
8					-					-		8
9	TOTAL Facility Related				21,707.00		\$ 3,032,000	\$ 2,515,139			\$ 144,555	9
	B. Non-Facility Related*											
10					-					-		10
11					-					-		11
12					-					-		12
13					-					-		13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,032,000	\$ 2,515,139			\$ 144,555	15

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

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

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

Facility Name & ID Number Maple Lawn Health Center

0042424 Report Period Beginning: 01/01/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2006 report.	\$	2,789	1	
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2,734	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	(55)	3	
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	2,802	4	
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5	
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6	
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	2,747	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2002	2,589		8	
	2003	2,603		9	
	2004	2,679		10	
	2005	2,734		11	
	2006	2,734		12	
<u>C/Y accrual based on prior year tax paid.</u>					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2006	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to the Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Maple Lawn Health Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0042424

CONTACT PERSON REGARDING THIS REPORT Garry Guimond

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/07

Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

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

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).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Health Center	85,000	1965	\$ 1,386	1
2	Health Center	39,000	1969	1,000	2
3	TOTALS			\$ 2,386	3

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80	Jan-65	Jan-65	\$ 472,000	\$ 8,524	60	\$ 7,867	\$ (657)	\$ 337,613	4
5		Jan-74	Jan-74	20,378	658	50	408	(250)	13,607	5
6		Jan-80	Jan-80	750,017	18,394	45	16,667	(1,727)	464,950	6
7		Jan-82	Jan-82	7,703		20			7,703	7
8	38	Jan-89	Jan-89	1,459,363	32,432	45	32,430	(2)	599,959	8
Improvement Type**										
9	Landscaping		Jan-82	1,155		20			1,155	9
10	Trees		Jan-84	1,125		20			1,125	10
11	Trees		Jan-84	1,976		20			1,976	11
12	Landscaping - Front of HC		Jan-92	1,100		10			1,100	12
13	Asphalt Repair		Jan-93	4,058		10			4,058	13
14	Parking Lot Lighting		Jan-95	1,282		10			1,282	14
15	Asphalt Parking Lot		Jan-95	2,528		10			2,528	15
16	ADU Enclosure		Jan-95	4,305		10			4,305	16
17	Parking Blocks (20)		Jan-96	654		10			654	17
18	Lower Level Renovation		Jan-81	203,080		23			203,080	18
19	Lower Level Renovation		Jan-82	35,963		22			35,963	19
20	Fixture Repairs & Refinish		Jan-83	11,150		10			11,150	20
21	Trellis		Jan-83	1,063		10			1,063	21
22	Loading Dock		Jan-85	1,642		20			1,642	22
23	Deck		Jan-92	2,574		10			2,574	23
24	Room Renovaton		Jan-92	1,067		10			1,067	24
25	Lobby Renovation		Jan-93	32,583		10			32,583	25
26	Central Supply Room		Jan-93	1,697		10			1,697	26
27	ADU Cabinets		Jan-94	1,365		12			1,365	27
28	Wallpaper		Jan-94	776		8			776	28
29	Wallpaper		Jan-95	1,181		8			1,181	29
30	Wallpaper		Jan-95	194		8			194	30
31	Carpet Room 702		Jan-95	203		8			203	31
32	Wallcovering Admin Office		Jan-95	732		8			732	32
33	Conference Room Wing 2		Jan-95	512		8			512	33
34	Lobby Carpet		Jan-96	19,386		10			19,386	34
35	Kitchen Ramp Floorcovering		Jan-96	526		8			526	35
36	Room Renovating		Jan-96	969		8			969	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/07 Ending: 12/31/07

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	Walk in Freezer	Jan-75	\$ 2,853	\$	10	\$	\$	\$ 2,853	37
38	Sprinkler Installation	Jan-76	11,240		20			11,240	38
39	Sprinkler Installation	Jan-77	743		20			743	39
40	Generator	Jan-80	9,500		20			9,500	40
41	Lite Fixture- Lobby	Jan-82	4,634		20			4,634	41
42	Floor Covering Ramps Renovation	Jan-82	1,116		10			1,116	42
43	Kitchen Air Vent	Jan-82	650		20			650	43
44	Exhaust Fan	Jan-84	2,800		20			2,800	44
45	Entrance Load Control	Jan-85	13,672		15			13,672	45
46	Light Fixtures	Jan-85	936		10			936	46
47	Water Softner	Jan-87	699		5			699	47
48	Alarm System	Jan-89	5,473		15			5,473	48
49	Wander Guard System	Jan-90	7,685		8			7,685	49
50	Door Alarms	Jan-90	1,461		8			1,461	50
51	Garbage Disposal	Jan-90	951		10			951	51
52	Air Conditioning Condenser	Jan-90	2,395		15			2,395	52
53	Air Conditioning Unit	Jan-91	3,105	156	20	155	(1)	2,561	53
54	Management System (5 Units)	Jan-91	1,163		15			1,163	54
55	Privacy Curtains	Jan-91	11,200		10			11,200	55
56	Water heater Tanks	Jan-92	12,622	140	15	142	2	12,622	56
57	Century Whirlpool Tub	Jan-93	3,284	219	15	219		3,230	57
58	Laundry Machine Motor	Jan-93	515		30			515	58
59	Assembly Room Sound System	Jan-93	1,410	93	15	94	1	1,347	59
60	Wander Guard Door Monitor	Jan-93	1,212		8			1,212	60
61	MTCO Telephone System	Jan-93	12,883		10			12,883	61
62	Paging System	Jan-94	707		3			707	62
63	ADU Door Monitoring System	Jan-94	914		3			914	63
64	Upgrade Elevator	Jan-94	3,298		10			3,298	64
65	Air Conditioning -Dining Room	Jan-94	1,723		20	86	86	1,148	65
66	Hatco Toaster	Jan-95	980		10			980	66
67	Fiber Optics Wiring	Jan-95	4,645		5			4,645	67
68	Dining Room A/C Unit	Jan-95	3,187	159	20	159		2,017	68
69	Wood Graphics Signs	Jan-95	1,131		7			1,131	69
70	TOTAL (lines 4 thru 69)		\$ 3,175,094	\$ 60,775		\$ 58,227	\$ (2,548)	\$ 1,887,059	70

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,175,094	\$ 60,775		\$ 58,227	\$ (2,548)	\$ 1,887,059	1
2	Kitchen Shelves / Counter	Jan-95	6,667	422	15	444	22	5,428	2
3	Parker Bath	Jan-95	8,598		10			8,598	3
4	Magnetic Door Lock System	Jan-96	2,846		10			2,846	4
5	Service Sink	Jan-96	656		10			656	5
6	Nurse Call System	Jan-96	21,777		10			21,777	6
7	A/C Unit -Central Supply Room	Jan-96	3,515		10			3,515	7
8	Elevator Upgrade	Jan-96	13,117		10			13,117	8
9	A/C Unit Laundry Room	Jan-96	5,986		10			5,986	9
10	A/C Unit Kitchen	Jan-96	5,688		10			5,688	10
11	Alarm System	Jan-96	709		8			709	11
12	Tektone Door Alarm	Jan-96	673		8			673	12
13	Vertical Blinds	Jan-94	1,021		8			1,021	13
14	Landscaping	Jan-97	3,116	104	10	103	(1)	3,116	14
15	Remodel Smoking Area	Jan-97	553	14	10	15	1	553	15
16	Patient Room Renovation	Jan-97	979		8			979	16
17	Lobby Renovation	Jan-97	499		9			499	17
18	Sink & Counter for Empl.Lounge	Jan-97	1,319		8			1,319	18
19	Fireplace Conversion	Jan-97	2,762		10	93	93	2,762	19
20	Kitchen Waterline Replacement	Jan-97	1,591	133	10	133		1,591	20
21	Chapel Renovation	Jan-97	17,045	1,704	10	1,703	(1)	17,045	21
22	Nurse Call System Cords	Jan-97	588		5			588	22
23	Addressable Fire alarm System	Jan-97	11,790	98	10	98		11,790	23
24	Fire Alarm Annunciator	Jan-97	985	33	10	31	(2)	985	24
25	Expansion Tank	Jan-97	3,800		8			3,800	25
26	Door Security Upgrade	Jan-97	2,843		10	96	96	2,843	26
27	Phone System Additions	Jan-97	821	82	10	82		821	27
28	Bathub	Jan-97	6,080	608	10	608		6,080	28
29	Bath Lift	Jan-97	3,294	329	10	329		3,292	29
30	Parking Lot Repair	Jan-98	1,829	183	10	183		1,677	30
31	Landscaping	Jan-98	700	70	10	70		659	31
32	Boiler Repairs	Jan-98	2,415		10	242	242	2,397	32
33	Automatic Door	Jan-98	3,651	366	10	365	(1)	3,529	33
34	TOTAL (lines 1 thru 33)		\$ 3,313,007	\$ 64,921		\$ 62,822	\$ (2,099)	\$ 2,023,398	34

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,313,007	\$ 64,921		\$ 62,822	\$ (2,099)	\$ 2,023,398	1
2	Wing 3 Renovation	Jan-98	2,825		10	283	283	2,592	2
3	Dining Room Renovation	Jan-98	13,665		10			13,665	3
4	Hall 3 Fire Detectors	Jan-98	1,794		8			1,794	4
5	Hall 2 Fire Detectors	Jan-98	2,994		8			2,994	5
6	Emergency Generator Repairs	Jan-98	1,356	136	10	136		1,301	6
7	Free Standing Bath	Jan-98	8,958	896	10	896		8,362	7
8	Security System/ADU Outdoor Gate	Jan-98	1,127		8			1,127	8
9	Cable System	Jan-98	24,353		5			24,353	9
10	A/C Lower Lobby - By Dining Rm	Jan-98	3,604	360	10	360		3,242	10
11	Asphalt Repair	Jan-99	2,467	247	10	247		2,057	11
12	Dining Room Renovation	Jan-99	1,428		10	143	143	1,251	12
13	Hall 6 Renovation	Jan-99	2,588	259	10	259		2,157	13
14	New Door for Entrance	Jan-99	2,665	267	10	267		2,178	14
15	Hall 7 Renovation	Jan-99	6,647	665	10	665		5,374	15
16	Bath Flooring	Jan-99	2,018	231	8	232	1	2,018	16
17	Janitor Floor	Jan-99	326	37	8	37		326	17
18	Hall 1 Renovation	Jan-99	2,276		8	259	259	2,276	18
19	Electronic Eye Door-Main Entrance	Jan-99	3,723	373	10	372	(1)	2,977	19
20	Office Renovation	Jan-99	2,458	245	10	246	1	1,967	20
21	Lounge Renovation	Jan-99	927	93	10	93		743	21
22	Door alarms Halls 1 & 3	Jan-99	4,285		8			4,285	22
23	Fire Alarms Halls 1,6,7	Jan-99	5,290	165	8	166	1	5,290	23
24	A/C Condensor	Jan-99	1,001	100	10	100		851	24
25	Adjustable Sink	Jan-99	2,569	321	8	321		2,569	25
26	Carousel Whirlpool	Jan-99	16,897	1,690	10	1,690		13,519	26
27	Heating A/C Unit Hall 6	Jan-99	998		10	100	100	799	27
28	Asphalt Repair	Jan-00	2,352	235	10	235		1,704	28
29	Tempered Water System Redesigned	Jan-00	14,400	720	20	720		5,520	29
30	Renovate Social Service Office	Jan-00	3,422	342	10	342		2,594	30
31	Wanderguard Monitors	Jan-00	2,591	324	8	324		2,497	31
32	New Boiler in Cleveland Steamer	Jan-00	4,076	408	10	408		2,957	32
33	Octel 100 Voicemail System	Jan-00	6,260		5			6,260	33
34	TOTAL (lines 1 thru 33)		\$ 3,465,347	\$ 73,035		\$ 71,723	\$ (1,312)	\$ 2,154,997	34

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,465,347	\$ 73,035		\$ 71,723	\$ (1,312)	\$ 2,154,997	1
2	Cable System Expansion	Jan-00	1,844		5			1,844	2
3	Land Improve- Sidewalk Replacement	Jan-01	485	49	10	49		297	3
4	Water System Installation	Jan-01	41,500	2,075	20	2,075		14,352	4
5	Administrative Office - Carpet	Jan-01	1,447	181	8	181		1,221	5
6	Fire Alarms- Halls 4 & 5	Jan-01	6,436	805	8	805		5,634	6
7	Air Condition Unit Hall 6	Jan-01	3,424	343	10	342	(1)	2,253	7
8	Door Alarms - Hall 7	Jan-01	2,757	345	8	345		2,155	8
9	Elevator Safety Edges	Jan-02	3,245	324	10	325	1	1,814	9
10	Reshingle - Memorial Hall	Jan-02	739	37	20	37		197	10
11	A/C Condensor - HC Lobby	Jan-02	785	78	10	79	1	427	11
12	Cable System Upgrade	Jan-02	1,138	152	5	150	(2)	1,138	12
13	Sandblasted Redwood Signs	Jan-02	736	105	7	105		534	13
14	Room 601 Construction	Jan-03	34,315	1,716	20	1,716		8,008	14
15	Room 306 Bathroom Conversion	Jan-03	21,425	2,142	10	2,143	1	10,000	15
16	PT Room Divider Curtain	Jan-03	2,589	259	10	259		1,209	16
17	Crosslink II Traverline Carpet	Jan-03	936	117	8	117		546	17
18	Insinkerator Disposer for Kitchen	Jan-03	1,048	209	5	210	1	980	18
19	New Exit Doors & Keypads	Jan-03	9,618	1,374	7	1,374		5,954	19
20	New Parking Lot	Jan-03	9,378	782	12	782		3,584	20
21	Wallpaper -Rm 302/Hall#1/Dining Rm	Jan-03	542	78	7	77	(1)	353	21
22	Wallpaper Stock for Room Renovations	Jan-03	600		7	86	86	394	22
23	Asbestos removal - Dining Rm Floor	Jan-03	10,520	1,503	7	1,503		6,513	23
24	Vinyl Flooring in Dining Rm	Jan-03	12,700	1,814	7	1,814		7,861	24
25	Wallpaper Hall 2	Feb-04	700	100	7	100		387	25
26	Expansion Dining Room	Feb-04	2,612	174	15	174		673	26
27	Flooring for Elevator	Jul-04	1,479	185	8	185		635	27
28	Walk-in Cooler	Mar-04	8,043	804	10	804		3,049	28
29	Door Lock	Mar-04	3,313	474	7	473	(1)	1,791	29
30	Telephone System	Apr-04	16,115	1,612	10	1,612		5,953	30
31	Draperies	Feb-04	733	105	7	105		408	31
32	Draperies	Apr-04	974	139	7	139		515	32
33	Sealcoat Parking Lot	Sep-04	2,479		3	619	619	2,479	33
34	TOTAL (lines 1 thru 33)		\$ 3,670,002	\$ 91,116		\$ 90,508	\$ (608)	\$ 2,248,155	34

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

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,670,002	\$ 91,116		\$ 90,508	\$ (608)	\$ 2,248,155	1
2	Landscaping	Jul-04	2,778	278	10	278		965	2
3	Renovation on resident rooms, hallways	Jan-05	670,114	22,940	30	22,337	(603)	66,950	3
4	Roof replacement	Jan-05	414,304	13,810	30	13,810		41,392	4
5	Resident room doors and refinishing	Jun-05	6,164	206	30	205	(1)	519	5
6	Carpet and Tile Flooring	Jun-05	39,119	2,608	15	2,608		6,531	6
7	Wallpaper for lobby	Jun-05	3,921	392	10	392		982	7
8	Sprinkler system	Jan-05	71,880	2,396	30	2,396		7,181	8
9	Lighting resident rooms and lobby.	Jun-05	4,754	158	30	158		400	9
10	Time clock system	Jun-05	34,290	3,429	10	3,429		8,587	10
11	Privacy track, window rods, draperies	Jan-05	5,678	717	7	811	94	2,431	11
12	Carpeting room 608	Mar-05	758	95	8	95		261	12
13	Wiring Upgrade	Jan-05	1,498	300	5	300		878	13
14	A/C condenser replacement	May-05	4,775	318	15	318		823	14
15	Boiler replacement	Apr-05	4,495	75	10	450	375	1,212	15
16	Asphalt Repairs	Jun-05	1,200	240	5	240		601	16
17	Renovate Multi-Rm/Nurse Station	Jun-05	85,586	2,853	30	2,853		7,144	17
18	Roof Replacement Dietary	Jul-05	14,503	484	30	483	(1)	1,171	18
19	Nurse Station Bumper Guards	Aug-05	491	98	5	98		235	19
20	Chimney roofing work	Aug-05	2,180	109	20	109		254	20
21	Install sink	Sep-05	1,345	90	15	90		203	21
22	Transfer switch	Jun-05	2,549	364	7	364		922	22
23	Sprinkler system	Jun-05	934	31	30	31		78	23
24	Air conditioning unit	Sep-05	3,300	220	15	220		509	24
25	Sprinkler head	Dec-05	1,458	45	30	49	4	100	25
26	Gas shut-off fire system	Aug-05	2,600	87	30	87		203	26
27	Fire alarm	Oct-05	11,087	739	15	739		1,630	27
28	Boiler pump	Dec-05	3,986	399	10	399		815	28
29	Door	Oct-06	1,379	138	10	138		161	29
30	Plumbing	Aug-06	1,023	102	10	102		136	30
31	Carpeting	Jan-06	2,618	262	10	262		502	31
32	Draperies	Feb-06	174	25	7	25		48	32
33	Dining Room Renovation	Feb-07	3,531	110	8	397	287	397	33
34	TOTAL (lines 1 thru 33)		\$ 5,074,474	\$ 145,234		\$ 144,781	\$ (453)	\$ 2,402,376	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	Totals from Page 12E, Carried Forward	\$ 5,074,474	\$ 145,234		\$ 144,781	\$ (453)	\$ 2,402,376	1
2	Public address system	461	54	5	57	3	57	2
3	Asphalt road repairs	18,979	778	15	842	64	842	3
4	Renovations room 701	1,371	112	8	115	3	115	4
5	Sidewalk repairs	3,054	153	10	168	15	168	5
6	Renovations room 707	1,208	75	8	86	11	86	6
7	Carpeting room 709	591	25	8	26	1	26	7
8	Renovations room 603	815	70	8	17	(53)	17	8
9	Renovations room 612	673	14	8	14		14	9
10	Renovations room 604	55	9	1	9		9	10
11	Wallcoverings hall and 4 rooms	1,400	29	8	22	(7)	22	11
12	Gate concrete pad	725	20	3	20		20	12
13	Plumbing wing 1	2,500	26	8	21	(5)	21	13
14	Fire alarm system upgrade	4,150	43	8	24	(19)	24	14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,110,456	\$ 146,642		\$ 146,202	\$ (440)	\$ 2,403,797	34

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 154,794	\$ 27,879	\$ 27,879	\$	various	\$ 130,254	71
72	Current Year Purchases	44,144	3,225	3,225		various	3,225	72
73	Fully Depreciated Assets	324,334				various	324,334	73
74								74
75	TOTALS	\$ 523,272	\$ 31,104	\$ 31,104	\$		\$ 457,813	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2001, Ford van	Mar-05	\$ 9,054	\$ 2,056	\$ 2,056	\$	5	\$ 7,941	76
77										77
78										78
79										79
80	TOTALS			\$ 9,054	\$ 2,056	\$ 2,056	\$		\$ 7,941	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,645,168 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,802 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,362 83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (440) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,869,551 85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	281 Walkway	\$ 21,141	\$ 1,001	\$ 13,453	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 21,141	\$ 1,001	\$ 13,453	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 175,239	92
93			93
94			94
95		\$ 175,239	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ _____ - Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	_____/2008	\$ _____
13.	_____/2009	\$ _____
14.	_____/2010	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

01/01/07 Ending: 12/31/07

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$	169	\$ 9,222				169	\$ 9,222	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		182	10,541				182	10,541	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs		203	11,673				203	11,673	4
5	Physician Care	39.3	visits									5
6	Dental Care	39.3	visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39.2	# of prescrpts					42,654			42,654	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program	39.2										12
13	Other (specify): <u>Medical Supplies</u>	39.2										13
14	TOTAL			\$	554	\$ 31,436	\$	42,654		554	\$ 74,090	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Maple Lawn Health Center# 0042424Report Period Beginning: 01/01/07Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07 (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	\$ 236,175	\$	1
2	Cash-Patient Deposits	9,146		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>61,874</u>)	627,053		3
4	Supply Inventory (priced at <u>FIFO</u>)	33,978		4
5	Short-Term Investments			5
6	Prepaid Insurance	300		6
7	Other Prepaid Expenses	12,441		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	333,889		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,252,982	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	109,851		12
13	Land	2,386		13
14	Buildings, at Historical Cost	4,428,773		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	933,398		16
17	Accumulated Depreciation (book methods)	(2,558,744)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Process</u>	175,239		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,090,903	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,343,885	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (351,096)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(9,146)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(94,148)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(2,802)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Accrued Expenses</u>	(33,429)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (490,621)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(2,526,377)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,526,377)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (3,016,998)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,326,887)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (4,343,885)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,409,194	1
2	Restatements (describe):		2
3	Prior Period Adjustments		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,409,194	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(82,307)	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (82,307)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,326,887	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 5,307,544	1
2	Discounts and Allowances for all Levels	(1,521,576)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,785,968	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	433,770	6
7	Oxygen	(65)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 433,705	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	300	12
13	Barber and Beauty Care	3,425	13
14	Non-Patient Meals	71,658	14
15	Telephone, Television and Radio	9,558	15
16	Rental of Facility Space		16
17	Sale of Drugs	29,929	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,543	19
20	Radiology and X-Ray	(37)	20
21	Other Medical Services	94,709	21
22	Laundry	437	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 212,522	23
D. Non-Operating Revenue			
24	Contributions	86,552	24
25	Interest and Other Investment Income***	4,460	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 91,012	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Admission Fee	17,013	28
28a	Miscellaneous	431	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,444	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,540,651	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,081,326	31
32	Health Care	1,952,258	32
33	General Administration	1,169,900	33
B. Capital Expense			
34	Ownership	328,092	34
C. Ancillary Expense			
35	Special Cost Centers	42,654	35
36	Provider Participation Fee	48,728	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,622,958	40
41	Income before Income Taxes (line 30 minus line 40)**	(82,307)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (82,307)	43

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

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

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

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,615	1,721	\$ 64,824	\$ 37.67	1
2	Assistant Director of Nursing	1,046	1,208	15,696	12.99	2
3	Registered Nurses	8,570	9,259	205,745	22.22	3
4	Licensed Practical Nurses	14,313	15,705	301,239	19.18	4
5	CNAs & Orderlies	58,379	63,987	770,463	12.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,886	2,145	25,567	11.92	8
9	Activity Director	1,856	2,080	31,150	14.98	9
10	Activity Assistants	1,788	2,089	24,066	11.52	10
11	Social Service Workers	3,300	3,454	56,847	16.46	11
12	Dietician	1,904	2,072	51,338	24.78	12
13	Food Service Supervisor	1,984	2,140	25,336	11.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,292	23,969	231,990	9.68	15
16	Dishwashers					16
17	Maintenance Workers	3,641	3,972	81,295	20.47	17
18	Housekeepers	6,166	6,872	81,302	11.83	18
19	Laundry	5,065	5,706	41,049	7.19	19
20	Administrator	1,224	1,224	72,872	59.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,171	4,669	50,784	10.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,200	152,272	\$ 2,131,563 *	\$ 14.00	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$	1.3	35
36	Medical Director	34	5,150	9.3	36
37	Medical Records Consultant	36	2,160	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	24	1,800	10.3	39
40	Physical Therapy Consultant	25	1,444	10a.3	40
41	Occupational Therapy Consultant	17	954	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	47	2,716	10a.3	43
44	Activity Consultant			11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	184	\$ 14,224		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	390	\$ 14,133	10.3	50
51	Licensed Practical Nurses	1,803	58,181	10.3	51
52	Certified Nurse Assistants/Aides	5,035	90,190	10.3/10a.3	52
53	TOTAL (lines 50 - 52)	7,228	\$ 162,504		53

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/07

Ending:

12/31/07

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 4,913
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.25
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 37,138 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,728
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 71,658
- (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? 100% Program
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not issued at time of filing cost report.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.