

Facility Name & ID Number Maple Lawn Health Center

0042424 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	18	Sheltered Care (SC)	18	6,570	5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,055	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF			1,956	1,956	8
9	SNF/PED					9
10	ICF	15,880	8,230		24,110	10
11	ICF/DD					11
12	SC		5,408		5,408	12
13	DD 16 OR LESS					13
14	TOTALS	15,880	13,638	1,956	31,474	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.59%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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 1922

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

YES Date 1922 NO

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

YES NO If YES, enter number of beds certified 89 and days of care provided 1,771

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	316,354	21,133		337,487		337,487		337,487		1
2	Food Purchase		338,302		338,302		338,302	(97,426)	240,876		2
3	Housekeeping	172,018	27,942	7,496	207,456		207,456		207,456		3
4	Laundry	38,672			38,672		38,672		38,672		4
5	Heat and Other Utilities			137,071	137,071		137,071		137,071		5
6	Maintenance	67,493	17,280	59,704	144,477		144,477	924	145,401		6
7	Other (specify):* Waste Removal			13,585	13,585		13,585		13,585		7
8	TOTAL General Services	594,537	404,657	217,856	1,217,050		1,217,050	(96,502)	1,120,548		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,793,852	122,404	41,018	1,957,274		1,957,274		1,957,274		10
10a	Therapy	31,709	1,544	319,525	352,778		352,778		352,778		10a
11	Activities	143,214	10,355	2,740	156,309		156,309		156,309		11
12	Social Services	41,553	1,138	2,675	45,366		45,366	4	45,370		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,010,328	135,441	377,958	2,523,727		2,523,727	4	2,523,731		16
	C. General Administration										
17	Administrative	128,418			128,418		128,418	2,561	130,979		17
18	Directors Fees										18
19	Professional Services			145,029	145,029		145,029	(17,630)	127,399		19
20	Dues, Fees, Subscriptions & Promotions			29,901	29,901		29,901	(1,143)	28,758		20
21	Clerical & General Office Expenses	243,013	27,061	49,170	319,244		319,244	1,563	320,807		21
22	Employee Benefits & Payroll Taxes			707,606	707,606		707,606		707,606		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,079	11,079		11,079	703	11,782		24
25	Other Admin. Staff Transportation		5,585	4,820	10,405		10,405	243	10,648		25
26	Insurance-Prop.Liab.Malpractice			143,099	143,099		143,099	1,690	144,789		26
27	Other (specify):*										27
28	TOTAL General Administration	371,431	32,646	1,090,704	1,494,781		1,494,781	(12,013)	1,482,768		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,976,296	572,744	1,686,518	5,235,558		5,235,558	(108,511)	5,127,047		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.

Facility Name & ID Number Maple Lawn Health Center

#0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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			231,998	231,998		231,998	8,093	240,091			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			261,740	261,740		261,740	(26,863)	234,877			32
33	Real Estate Taxes			34,816	34,816		34,816	(12,303)	22,513			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Loan Costs			7,728	7,728		7,728		7,728			36
37	TOTAL Ownership			536,282	536,282		536,282	(31,073)	505,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,111		41,111		41,111		41,111			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,075	195,075		195,075		195,075			42
43	Other (specify):* Non-allowable Costs	121,840	3,754	163,578	289,172		289,172	(289,172)				43
44	TOTAL Special Cost Centers	121,840	44,865	358,653	525,358		525,358	(289,172)	236,186			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,098,136	617,609	2,581,453	6,297,198		6,297,198	(428,756)	5,868,442			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: 1/1/2014

Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,856)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,643)	30		9
10	Interest and Other Investment Income	(11,792)	32		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	(15,071)	32		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	(13,220)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,399)	43		24
25	Fund Raising, Advertising and Promotional	(213,156)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(156,369)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (457,506)		\$	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)	28,750		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 28,750		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (428,756)		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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Maple Lawn Health Center

ID# 0042424

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Flowers	\$ (19)	43	1
2	Offset vending income and meal income	(97,426)	2	2
3	Offset Miscellaneous income	(4,800)	21	3
4	Loss on Sale of Fixed Asset	(25,227)	43	4
5	Nonallowable dues	(2,276)	20	5
6	Allocated Property Tax Expense	(12,181)	33	6
7	Disallow Laboratory	(7,515)	43	7
8	Disallow Fundraising computer software exp	(6,925)	19	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(156,369)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(97,426)	0	0	0	0	0	0	0	0	0	0	(97,426)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	924	0	0	0	0	0	0	0	0	0	924	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(97,426)	924	0	(96,502)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	4	0	0	0	0	0	0	0	0	0	4	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	4	0	4	16								
	C. General Administration													
17	Administrative	0	2,561	0	0	0	0	0	0	0	0	0	2,561	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,145)	2,515	0	0	0	0	0	0	0	0	0	(17,630)	19
20	Fees, Subscriptions & Promotions	(2,276)	1,133	0	0	0	0	0	0	0	0	0	(1,143)	20
21	Clerical & General Office Expenses	(4,800)	6,363	0	0	0	0	0	0	0	0	0	1,563	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	703	0	0	0	0	0	0	0	0	0	703	24
25	Other Admin. Staff Transportation	0	243	0	0	0	0	0	0	0	0	0	243	25
26	Insurance-Prop.Liab.Malpractice	0	1,690	0	0	0	0	0	0	0	0	0	1,690	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,221)	15,208	0	(12,013)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(124,647)	16,136	0	(108,511)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2014 Ending:

12/31/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(4,643)	12,736	0	0	0	0	0	0	0	0	0	8,093	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,863)	0	0	0	0	0	0	0	0	0	0	(26,863)	32
33	Real Estate Taxes	(12,181)	(122)	0	0	0	0	0	0	0	0	0	(12,303)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(43,687)	12,614	0	(31,073)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(289,172)	0	0	0	0	0	0	0	0	0	0	(289,172)	43
44	TOTAL Special Cost Centers	(289,172)	0	0	0	0	0	0	0	0	0	0	(289,172)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(457,506)	28,750	0	(428,756)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Maple Lawn Association of Churches, Inc.				Maple Lawn Apartments, Inc	Eureka	Ret. Housing
				Maple Lawn Total Living Care, Inc.	Eureka	Home Care
				Maple Lawn Homes, I	Eureka	Support Services

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 Maintenance	\$	Maple Lawn Homes, Inc.	0.00%	\$ 924	\$ 924	1
2	V	12 Social Services		Maple Lawn Homes, Inc.	0.00%	4	4	2
3	V	17 Administrative		Maple Lawn Homes, Inc.	0.00%	2,561	2,561	3
4	V	19 Professional Services		Maple Lawn Homes, Inc.	0.00%	2,515	2,515	4
5	V	20 Fees, Subscriptions & Promotions		Maple Lawn Homes, Inc.	0.00%	1,133	1,133	5
6	V	21 Clerical & General Office		Maple Lawn Homes, Inc.	0.00%	6,363	6,363	6
7	V	24 Travel and Seminar		Maple Lawn Homes, Inc.	0.00%	703	703	7
8	V	25 Other Admin Staff Transportation		Maple Lawn Homes, Inc.	0.00%	243	243	8
9	V	26 Insurance		Maple Lawn Homes, Inc.	0.00%	1,690	1,690	9
10	V	30 Depreciation		Maple Lawn Homes, Inc.	0.00%	12,736	12,736	10
11	V	33 Real Estate Taxes		Maple Lawn Homes, Inc.	0.00%	(122)	(122)	11
12	V							12
13	V							13
14	Total		\$			\$ 28,750	\$ * 28,750	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors:							1
2								2
3	Alice Kennell	0						3
4	Dave Neuhauser – Treasurer	0						4
5	Leanne Schertz	0						5
6	Troy Teater - Vice Chair	0						6
7	Carol Springer	0						7
8	Don Litwiller – Chairman	0						8
9	Lisa Jablonski - Secretary	0						9
10	Minta Colburn	0						10
11	Lindsay Churchman	0						11
12	Eldon Schlupp	0						12
13	Joe Burns	0						13
14								14
15								15
16								16
17	Note: No Board Members received compensation from the facility.							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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	N/A										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:

1/1/2014

Ending: 2/31/2014

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	6	Maintenance	Accumulated Cost 8,916,202	4	\$ 1,313	\$	6,271,971	\$ 924	1
2	12	Social Services	Accumulated Cost 8,916,202	4	5		6,271,971	4	2
3	17	Administrative	Accumulated Cost 8,916,202	4	3,641		6,271,971	2,561	3
4	19	Professional Services	Accumulated Cost 8,916,202	4	3,575		6,271,971	2,515	4
5	20	Fees, Subscriptions & Promotions	Accumulated Cost 8,916,202	4	1,610		6,271,971	1,133	5
6	21	Clerical & General Office	Accumulated Cost 8,916,202	4	9,046		6,271,971	6,363	6
7	24	Travel and Seminar	Accumulated Cost 8,916,202	4	999		6,271,971	703	7
8	25	Other Admin Staff Transportatio	Accumulated Cost 8,916,202	4	346		6,271,971	243	8
9	26	Insurance	Accumulated Cost 8,916,202	4	2,402		6,271,971	1,690	9
10	30	Depreciation	Accumulated Cost 8,916,202	4	18,106		6,271,971	12,736	10
11	33	Real Estate Taxes	Accumulated Cost 8,916,202	4	(173)		6,271,971	(122)	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				\$ 40,870	\$		\$ 28,750	25

Facility Name & ID Number

Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense					
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO											Original	Balance		
A. Directly Facility Related																	
Long-Term																	
1	Lancaster Pollard Mtg Co		X	Building	\$23,751.45	12/1/13	4,480,400	4,418,722	12/1/43	0.0489	\$	217,594					
2																	
3																	
4																	
5																	
Working Capital																	
6	Heartland Bank & Trust		X	Line of credit	varies	2004	112,000	946,130	2008	0.0600		44,146					
7																	
8																	
9	TOTAL Facility Related				\$23,751.45		\$ 4,592,400	\$ 5,364,852			\$	261,740					
B. Non-Facility Related*																	
10																	
11												10					
11												Non Health Center Interest Exp					
12												(15,071)					
12												Medicaid interest income offset					
13												(11,792)					
13																	
14	TOTAL Non-Facility Related						\$	\$			\$	(26,863)					
15	TOTALS (line 9+line14)						\$ 4,592,400	\$ 5,364,852			\$	234,877					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,804 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.				\$	24,827 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.)	2013			\$	34,803 2
3. Under or (over) accrual (line 2 minus line 1).				\$	9,976 3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	40,548 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.			Maple Lawn Homes, Inc. Alloc. Adjustment - see below		(122) (27,889)
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(28,011) 6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	22,513 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	2,722	8	FOR BHF USE ONLY	
	2010	2,757	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	2,771	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	37,314	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	34,803	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>Accrual based on prior year tax bill for the Administrative building and adjacent land</u>					
<u>Adjustments to Expense:</u>					
<u>Adj Accrual to computed</u>		-15708			
<u>Disallow portion of RE Tax</u>		-12181			

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.

2013 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 Jeremy LaKosh
 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 2013 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 2013.

(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>13-12-201-030</u>	<u>700 N. Main Street</u>	\$ <u>31,416.02</u>	\$ <u>20,421.00</u>
2. <u>13-12-201-029</u>	<u>700 N. Main Street</u>	\$ <u>3,386.84</u>	\$ <u>2,201.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>34,802.86</u></u>	\$ <u><u>22,622.00</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? X YES NO

If YES, attach an explanation and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Maple Lawn Health Center

0042424 Report Period Beginning:

1/1/2014 Ending:

12/31/2014

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).

Maple Lawn Homes, Inc. - Residential Housing, Administrative & General Services

Maple Lawn Apartments, Inc. - Retirement Housing

Maple Lawn Total Living Care, Inc. - Home Care

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Health Center</u>	<u>85,000</u>	<u>1965</u>	<u>\$ 1,386</u>	1
2	<u>Health Center</u>	<u>39,000</u>	<u>1969</u>	<u>1,000</u>	2
3	TOTALS	124,000		\$ 2,386	3

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	1965	1965	\$ 472,000	\$ 7,867	60	\$ 7,867	\$	\$ 392,682	4
5		1974	1974	20,378	408	50	408		16,463	5
6		1980	1980	750,017	16,667	45	16,667		581,619	6
7		1982	1982	7,703		20			7,703	7
8	38	1989	1989	1,459,363	32,430	45	32,430		826,969	8
Improvement Type**										
9	Landscaping		1982	1,155		20			1,155	9
10	Trees		1984	3,101		20			3,101	10
11	Landscaping - Front of HC		1992	1,100		10			1,100	11
12	Asphalt Repair		1993	4,058		10			4,058	12
13	Parking Lot Lighting & Asphalt		1995	3,810		10			3,810	13
14	ADU Enclosure		1995	4,305		10			4,305	14
15	Parking Blocks (20)		1996	654		10			654	15
16	Lower Level Renovation		1981	203,080		23			203,080	16
17	Lower Level Renovation		1982	35,963		22			35,963	17
18	Fixture Repairs & Refinish, Trellis		1983	12,213		10			12,213	18
19	Loading Dock		1985	1,642		20			1,642	19
20	Deck & Room Renovation		1992	3,641		10			3,641	20
21	Lobby Renovation & Central supply rm		1993	34,280		10			34,280	21
22	ADU Cabinets & Wallpaper		1994	2,141		10			2,141	22
23	Wallpaper, Carpet rm 702, Admin office		1995	2,822		8			2,822	23
24	Lobby Carpet,Kitchen ramp, rm renovate		1996	20,881		10			20,881	24
25	Walk in Freezer		1975	2,853		10			2,853	25
26	Sprinkler Installation		1976	11,240		20			11,240	26
27	Sprinkler Installation		1977	743		20			743	27
28	Generator		1980	9,500		20			9,500	28
29	Lighting, Flooring, Air Vent		1982	6,400		20			6,400	29
30	Exhaust Fan		1984	2,800		20			2,800	30
31	Entrance Load Control & Lighting		1985	14,608		10			14,608	31
32	Water Softner		1987	699		5			699	32
33	Alarm System		1989	5,473		15			5,473	33
34	Wander Guard,Door Alarms,Disposal,A/C		1990	12,492		8			12,492	34
35	A/C, Mgmt Sys, Curtains		1991	15,468		20			15,468	35
36	Water heater Tanks		1992	12,622		15			12,622	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
37	Tub,Motor,Sound Sys,Wander Guard,Tele Sys	1993	\$ 17,894	\$	10	\$	\$	\$ 17,894	37
38	Paging Sys,Door Monitor,elevator,A/C	1994	6,642		10			6,642	38
39	Toaster,Fiber Optics,A/C,Signage,Counter,Bath	1995	25,208		10			25,208	39
40	Door Lock,Sink,NurseCall,A/C,Elevator,AlarmSys	1996	54,967		10			54,967	40
41	Vertical Blinds	1994	1,021		8			1,021	41
42	Landscape,room remodel,sink,fireplace,waterline	1997	27,864		10			27,864	42
43	CallSys,FireAlarm,ExpTank,DoorSec,Phone,Tub	1997	30,201		10			30,201	43
44	Landscape,Boiler,Door,Fire,Generator,Bath,Security,A/C,Cable,P	1998	63,791		10			63,791	44
45	Asphalt,DiningRm,Hall,Door,Bath,ElecEye	1999	12,436		10			12,436	45
46	Office,Lounge,Door,Fire,A/C,Sink,Tub	1999	34,425		10			34,425	46
47	Tempered Water System Redesigned	2000	14,400	720	20	720		10,560	47
48	Renovate Social Service Office	2000	3,422		10			3,422	48
49	Wanderguard Monitors	2000	2,591		8			2,591	49
50	Octel 100 Voicemail System	2000	6,260		5			6,260	50
51	Cable System Expansion	2000	1,844		5			1,844	51
52	Water System Installation	2001	41,500	2,075	20	2,075		28,877	52
53	Fire Alarms- Halls 4 & 5	2001	6,436		8			6,436	53
54	Air Condition Unit Hall 6	2001	3,424		10			3,424	54
55	Door Alarms - Hall 7	2001	2,757		8			2,757	55
56	Elevator Safety Edges	2002	3,245		10			3,245	56
57	Cable System Upgrade	2002	1,138		5			1,138	57
58	Room 601 Construction	2003	34,315	1,716	20	1,716		20,020	58
59	Room 306 Bathroom Conversion	2003	21,425		10			21,425	59
60	PT Room Divider Curtain	2003	2,589		10			2,589	60
61	Insinkerator Disposer for Kitchen	2003	1,048		5			1,048	61
62	New Exit Doors & Keypads	2003	9,618		7			9,618	62
63	Asbestos removal - Dining Rm Floor	2003	10,520		7			10,520	63
64	Vinyl Flooring in Dining Rm	2003	12,700		7			12,700	64
65	Expansion Dining Room	2004	2,612	174	15	174		1,891	65
66	Flooring for Elevator	2004	1,479		8			1,479	66
67	Walk-in Cooler	2004	8,043	170	10	170		8,043	67
68	Door Lock	2004	3,313		7			3,313	68
69	Telephone System	2004	16,115	490	10	490		16,115	69
70	TOTAL (lines 4 thru 69)		\$ 3,624,448	\$ 62,717		\$ 62,717	\$	\$ 2,708,944	70

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 3,624,448	\$ 62,717		\$ 62,717	\$	\$ 2,708,944	1
2	Sealcoat Parking Lot	2004	2,479		3			2,479	2
3	Landscaping	2004	2,778	145	10	145		2,778	3
4	Renovation on resident rooms, hallways	2005	614,348	22,942	30	20,478	(2,464)	204,724	4
5	Roof replacement	2005	414,304	13,810	30	13,810		138,062	5
6	Resident room doors and refinishing	2005	6,164	205	30	205		1,954	6
7	Carpet and Tile Flooring	2005	20,031	1,335	15	1,335		12,686	7
8	Sprinkler system	2005	71,880	2,396	30	2,396		23,953	8
9	Lighting resident rooms and lobby.	2005	4,754	158	30	158		1,506	9
10	Privacy track, window rods, draperies	2005	5,678		7			5,678	10
11	Wiring Upgrade	2005	1,498		5			1,498	11
12	A/C condenser replacement	2005	4,775	318	15	318		3,049	12
13	Renovate Multi-Rm/Nurse Station	2005	85,586	2,853	30	2,853		27,115	13
14	Roof Replacement Dietary	2005	14,503	483	30	483		4,552	14
15	Chimney roofing work	2005	2,180	109	20	109		1,017	15
16	Install sink	2005	1,345	90	15	90		833	16
17	Transfer switch	2005	2,549		7			2,549	17
18	Sprinkler head	2005	1,458	49	30	49		443	18
19	Gas shut-off fire system	2005	2,600	87	30	87		812	19
20	Fire alarm	2005	11,087	739	15	739		6,803	20
21	Boiler pump	2005	3,986	399	10	399		3,608	21
22	Door	2006	1,379	138	10	138		1,127	22
23	Plumbing	2006	1,023	102	10	102		850	23
24	Carpeting	2006	2,618	262	10	262		2,336	24
25	Draperies	2006	174		7			174	25
26	Dining room wallpaper, lighting	2007	3,531	275	8	441	166	3,484	26
27	Public address system	2007	461		5			461	27
28	Room 701 flooring, lighting	2007	1,371	90	8	148	58	1,289	28
29	Sidewalk repairs	2007	3,054	328	10	305	(23)	2,303	29
30	Room 707 flooring, cabinetry	2007	1,208	148	8	148		1,140	30
31	Carpeting room 709	2007	591	74	8	74		544	31
32	Room 603 wallpaper, window coverings, lighting	2007	815	4	8	102	98	731	32
33	Room 612, lighting, flooring	2007	673	84	8	84		602	33
34	TOTAL (lines 1 thru 33)		\$ 4,915,329	\$ 110,340		\$ 108,175	\$ (2,165)	\$ 3,170,084	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 4,915,329	\$ 110,340		\$ 108,175	\$ (2,165)	\$ 3,170,084	1
2	Room 604 window coverings	2007	55		1			55	2
3	Wallcoverings hall and 4 rooms	2007	1,400	175	8	175		1,247	3
4	Gate concrete pad	2007	725		3			725	4
5	Plumbing wing 1	2007	2,500	313	8	313		2,212	5
6	Fire alarm system upgrade	2007	4,150	100	8	519	419	3,657	6
7	Driveway curbing	2008	3,300	220	15	220		1,460	7
8	Plumbing, lighting, wallpaper	2008	7,686	864	8	961	97	6,690	8
9	Carpeting and door replacement	2008	1,200	137	8	150	13	1,044	9
10	Fireproofing and sprinklers	2008	33,288	3,376	15	2,219	(1,157)	15,223	10
11	Drainage work	2008	3,460	231	15	231		1,560	11
12	Eyewash station in kitchen	2008	1,250	156	8	156		1,044	12
13	Baseboards, wallpaper, carpeting	2008	1,825	186	10	186		1,238	13
14	Air conditioning repairs	2008	6,800	850	8	850		5,503	14
15	Elevator repairs	2008	1,206		3			1,206	15
16	Emergency exit lighting	2008	1,394	174	8	174		1,103	16
17	Bath tub fixture	2008	729	49	15	49		297	17
18	Wing 1 & Hall 1 draperies, wallpaper, lighting	2008	5,423	1,040	8	678	(362)	4,406	18
19	Draperies, wallpaper, & baseboards	2008	7,251	776	8	906	130	6,308	19
20	Contractor labor & materials for dining room	2008	12,087	1,511	8	1,511		10,519	20
21	Dining room tear-down, tiling, painting, trim	2008	5,716	715	8	715		4,977	21
22	Gazebo shingles & vinyl	2009	372	61	7	53	(8)	287	22
23	Chapel fans, shades, ceiling tile & fixtures	2009	9,289	680	5	680		9,013	23
24	Flooring for rooms 705, 605, 609	2009	1,915	192	10	192		983	24
25	Sod, mulch, road repairs	2010	2,170	163	15	145	(18)	586	25
26	Carpet, Vinyl, Blinds front office & restroom	2010	3,856	612	10	386	(226)	1,880	26
27	2 boiler pumps and douglas fir	2011	3,356	224	15	224		684	27
28	Circuit breaker, wall heater, wanderguard monitor, A/C	2011	4,138	218	15	218		1,011	28
29	Serenity walls, floor, electrical	2011	80,450	5,363	15	5,363		19,219	29
30	Physician office floor, wall, electrical	2011	7,767	518	15	518		1,598	30
31	Fire Safety doors	2012	7,730	515	15	515		1,245	31
32	Smoke dampers	2012	7,178	256	28	256		640	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,144,995	\$ 130,015		\$ 126,738	\$ (3,277)	\$ 3,277,704	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 5,144,995	\$ 130,015		\$ 126,738	\$ (3,277)	\$ 3,277,704	1
2	Wing 5 remodel - window replacement, painting, electrical, flooring	2012	27,808	4,115	10	2,781	(1,334)	7,962	2
3	Landscaping - Administration Building	2009	6,435	858	5	858		6,435	3
4	Administration Building	2009	1,710,294	42,757	40	42,757		114,019	4
5	Administration Building key fob entry system	2009	1,532	153	10	153		419	5
6	Administration Building wooden sign	2009	2,065	138	15	138		414	6
7	Wing 1 remodel - window replacement, painting, wallpaper, beadboard	2013	32,884	3,707	10	3,288	(419)	5,206	7
8	Wing 6 & 7 remodel - painting, carpeting, room signs	2013	14,946	1,633	10	1,495	(138)	2,367	8
9	7 new Sprinkler Heads	2013	4,800	320	15	320		346	9
10	Boiler Repair	2013	1,826	122	15	122		203	10
11	Wanderguard System	2013	1,524	102	15	102		110	11
12	Construct Retaining Wall on Side Entrance	2014	8,145	226	15	226		226	12
13	Lighting Added at Circle Drive	2014	7,679		15				13
14	Resurface Circle Drive & Entrances, Add Additional Parking	2014	56,319	313	15	313		313	14
15	Wing 3, MPR & Hospice Room- Flooring, Painting Plumbing, Wai	2014	20,321	994	10	847	(147)	847	15
16	Wing 6 Tubroom Flooring	2014	2,561	43	10	43		43	16
17	Living Room & Entryway Renovation- Paint and Flooring	2014	32,971	550	5	550		550	17
18	Airconditioner Unit for Kitchen	2014	12,941	193	28	193		193	18
19	Repair Ceiling in Hall 3	2014	2,825		10	235	235	235	19
20	Repair Ceiling in Kitchen	2014	4,348		10	290	290	290	20
21	Remove Broken off Gutters from Main Sewer Line	2014	2,760		10				21
22									22
23									23
24									24
25									25
26									26
27	Maple Lawn Homes, Inc. Alloc.					2,456	2,456		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,099,979	\$ 186,239		\$ 183,905	\$ (2,334)	\$ 3,417,882	34

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

Facility Name & ID Number **Maple Lawn Health Center**

0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 357,781	\$ 37,156	\$ 37,156	\$	various	\$ 278,388	71
72	Current Year Purchases	91,102	8,603	8,750	147	5-15 yrs	8,750	72
73	Fully Depreciated Assets	122,160				various	122,160	73
74	Maple Lawn Homes, Inc. Alloc.			10,280	10,280			74
75	TOTALS	\$ 571,043	\$ 45,759	\$ 56,186	\$ 10,427		\$ 409,298	75

D. Vehicle Costs. (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	2005	\$ 9,054	\$	\$	\$	5	\$ 9,054	76
77										77
78										78
79										79
80	TOTALS			\$ 9,054	\$	\$	\$		\$ 9,054	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)	\$ 7,682,462	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 231,998	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 240,091	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,093	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,836,234	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 - 1980	\$ 21,141	\$ 480	\$ 16,816	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 21,141	\$ 480	\$ 16,816	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ N/A 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	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	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.

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/2014 Ending: 12/31/2014
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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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		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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,234	\$ 120,783	\$	6,234	\$ 120,783	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		732	30,606		732	30,606	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A (2), (3)	hrs		8,125	159,761	1,544	8,125	161,305	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				41,111		41,111	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	15,091	\$ 311,150	\$ 42,655	15,091	\$ 353,805	14	

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

Facility Name & ID Number Maple Lawn Health Center# 0042424Report Period Beginning: 1/1/2014

Ending:

12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 288,288	\$ 288,288	1
2	Cash-Patient Deposits	8,139	8,139	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>8,821</u>)	722,252	722,252	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,555	21,555	6
7	Other Prepaid Expenses	12,347	12,347	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	1,623,417	1,623,417	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,675,998	\$ 2,675,998	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	157,996	157,996	12
13	Land	2,386	2,386	13
14	Buildings, at Historical Cost	6,830,751	7,099,979	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	590,879	580,097	16
17	Accumulated Depreciation (book methods)	(3,729,539)	(3,836,234)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,090,470	1,090,470	21
22	Other Long-Term Assets (spec <u>Ppd loan costs</u>)	230,717	230,717	22
23	Other(specify): <u>Work in Progress</u>	165,110	165,110	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,338,770	\$ 5,490,521	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,014,768	\$ 8,166,519	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 314,650	\$ 314,650	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,139	8,139	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	188,826	188,826	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,548	40,548	32
33	Accrued Interest Payable	2,675	2,675	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	95,972	95,972	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 650,810	\$ 650,810	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	946,130	946,130	39
40	Mortgage Payable	4,418,722	4,418,722	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)	\$ 5,364,852	\$ 5,364,852	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,015,662	\$ 6,015,662	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,999,106	\$ 2,150,857	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,014,768	\$ 8,166,519	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,414,008	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,414,008	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(414,902)	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)	\$ (414,902)	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)	\$ 1,999,106	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maple Lawn Health Center# 0042424Report Period Beginning: 1/1/2014Ending: 12/31/2014

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,274,948	1
2	Discounts and Allowances for all Levels	(1,658,632)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,616,316	3
B. Ancillary Revenue			
4	Day Care	520	4
5	Other Care for Outpatients		5
6	Therapy	571,127	6
7	Oxygen	19,027	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 590,674	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	743	12
13	Barber and Beauty Care	2,520	13
14	Non-Patient Meals	96,683	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,689	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,695	19
20	Radiology and X-Ray	902	20
21	Other Medical Services	174,770	21
22	Laundry	309	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 318,311	23
D. Non-Operating Revenue			
24	Contributions	334,630	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 334,630	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	5,773	28
28a	Miscellaneous Income	16,592	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,365	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,882,296	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,217,050	31
32	Health Care	2,523,727	32
33	General Administration	1,494,781	33
B. Capital Expense			
34	Ownership	536,282	34
C. Ancillary Expense			
35	Special Cost Centers	330,283	35
36	Provider Participation Fee	195,075	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,297,198	40
41	Income before Income Taxes (line 30 minus line 40)**	(414,902)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (414,902)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,888,024	44
45	Private Pay - Net Inpatient Revenue	2,403,467	45
46	Medicare - Net Inpatient Revenue	300,193	46
47	Other-(specify) <u>Managed Care</u>	24,632	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,616,316	49

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

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

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

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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	2,024	2,408	\$ 82,945	\$ 34.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,043	16,294	445,023	27.31	3
4	Licensed Practical Nurses	11,297	12,475	276,405	22.16	4
5	CNAs & Orderlies	71,129	77,611	968,235	12.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,747	1,971	31,709	16.09	8
9	Activity Director	1,840	2,080	32,942	15.84	9
10	Activity Assistants	5,265	5,799	65,244	11.25	10
11	Social Service Workers	2,008	2,080	41,553	19.98	11
12	Dietician	1,912	2,080	52,571	25.27	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,560	22,360	263,783	11.80	15
16	Dishwashers					16
17	Maintenance Workers	3,055	3,544	67,493	19.04	17
18	Housekeepers	12,266	13,427	172,018	12.81	18
19	Laundry	3,767	4,016	38,672	9.63	19
20	Administrator	1,692	1,872	128,418	68.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,264	1,352	56,330	41.66	23
24	Clerical	9,472	10,366	186,683	18.01	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	1,630	1,921	21,244	11.06	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	7,116	7,802	166,868	21.39	33
34	TOTAL (lines 1 - 33)	173,087	189,458	\$ 3,098,136 *	\$ 16.35	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	\$		35	
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	44	9,734	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	8,375	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,740	L11, C3	44
45	Social Service Consultant	35	2,675	L12, C3	45
46	Other(specify) <u>Dental</u>	Monthly	500	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	\$ 36,024		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	175	\$ 5,978	L10, C3	50
51	Licensed Practical Nurses	457	14,661	L10, C3	51
52	Certified Nurse Assistants/Aides	520	10,145	L10, C3	52
53	TOTAL (lines 50 - 52)	1,152	\$ 30,784		53

Maple Lawn Health Center

Period Beginning 1/1/2014
Period End 12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Transportation	1,450	1,572	16,700	10.62
Chaplain	966	1,040	28,328	27.24
Community Relations	1,798	1,973	45,039	22.83
Marketing/Dev	2,902	3,217	76,801	23.87
TOTAL	<u>7,116</u>	<u>7,802</u>	<u>166,868</u>	

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

1/1/2014

Ending:

12/31/2014**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. 3,653 IHCA
- (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? 5-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,909 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? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 195,075
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. \$ 10,596 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 97,426
- (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
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold-Banwart Ltd.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.