



Facility Name & ID Number Maple Lawn Health Center

# 0042424 Report Period Beginning: 01-Jan-09 Ending: 31-Dec-09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	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	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,450	35	3,430	4,915	8
9	SNF/PED					9
10	ICF	11,147	10,692		21,839	10
11	ICF/DD					11
12	SC		5,501		5,501	12
13	DD 16 OR LESS					13
14	TOTALS	12,597	16,228	3,430	32,255	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.89%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
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 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 3,430

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 31-Dec-09 Fiscal Year: 31-Dec-09  
\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01-Jan-09 Ending: 31-Dec-09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	300,304	23,957		324,261		324,261		324,261		1
2	Food Purchase		285,146		285,146		285,146	(80,601)	204,545		2
3	Housekeeping	122,325	14,143	1,078	137,546		137,546		137,546		3
4	Laundry	19,968	12,641		32,609		32,609	(150)	32,459		4
5	Heat and Other Utilities			146,803	146,803		146,803	17,720	164,523		5
6	Maintenance	46,078	5,442	97,794	149,314		149,314	3,050	152,364		6
7	Other (specify):*										7
8	TOTAL General Services	488,675	341,329	245,675	1,075,679		1,075,679	(59,981)	1,015,698		8
	B. Health Care and Programs										
9	Medical Director			7,700	7,700		7,700		7,700		9
10	Nursing and Medical Records	1,525,079	97,782	146,806	1,769,667		1,769,667		1,769,667		10
10a	Therapy	49,206	2,548	275,007	326,761		326,761		326,761		10a
11	Activities	55,841	4,566	4,217	64,624		64,624		64,624		11
12	Social Services	81,172	1,019		82,191		82,191		82,191		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,711,298	105,915	433,730	2,250,943		2,250,943		2,250,943		16
	C. General Administration										
17	Administrative	56,752		387,571	444,323		444,323	(387,571)	56,752		17
18	Directors Fees										18
19	Professional Services			75,568	75,568		75,568	12,417	87,985		19
20	Dues, Fees, Subscriptions & Promotions			52,888	52,888	757	53,645	(5,656)	47,989		20
21	Clerical & General Office Expenses	244,470	5,246	26,263	275,979	4,866	280,845	41,029	321,874		21
22	Employee Benefits & Payroll Taxes			751,248	751,248		751,248	145,102	896,350		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,210	5,210	(1,750)	3,460		3,460		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,080	61,080		61,080	1,159	62,239		26
27	Other (specify):*										27
28	TOTAL General Administration	301,222	5,246	1,359,828	1,666,296	3,873	1,670,169	(193,520)	1,476,649		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,501,195	452,490	2,039,233	4,992,918	3,873	4,996,791	(253,501)	4,743,290		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

Page 4

Facility Name & ID Number Maple Lawn Health Center #0042424 Report Period Beginning: 01-Jan-09 Ending: 31-Dec-09

## 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			174,300	174,300		174,300	51,408	225,708			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			132,972	132,972		132,972	1,482	134,454			32
33	Real Estate Taxes			3,000	3,000		3,000	1	3,001			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,113	1,113		1,113		1,113			35
36	Other (specify):*											36
37	TOTAL Ownership			311,385	311,385		311,385	52,891	364,276			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,535		73,535		73,535		73,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,601	52,601	(3,873)	48,728		48,728			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		73,535	52,601	126,136	(3,873)	122,263		122,263			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,501,195	526,025	2,403,219	5,430,439		5,430,439	(200,610)	5,229,829			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-Jan-09

Ending:

31-Dec-09

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	Reference	BHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(80,240)	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	5,534	30.3		9
10 Interest and Other Investment Income	(1,014)	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		43.3		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	(97,350)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,070)		\$	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)	(27,540)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (27,540)		36
(sum of SUBTOTALS)			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (200,610)		37

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Maple Lawn Health Center

# 0042424

Report Period Beginning:

01-Jan-09

Ending:

Page 6

31-Dec-09

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Maple Lawn Homes, Inc.	100%			Maple Lawn Apartments, Inc.	Eureka	Ret. Housing
				Maple Lawn Total Living Care, Inc.	Eureka	Home Care

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	Maple Lawn Homes, Inc.	100.00%	\$ 17,720	\$	17,720	1
2	V	6 Maintenance		Maple Lawn Homes, Inc.	100.00%	11,472		11,472	2
3	V	12 Social Services		Maple Lawn Homes, Inc.	100.00%				3
4	V	19 Professional Service		Maple Lawn Homes, Inc.	100.00%	12,417		12,417	4
5	V	21 Administrative and General		Maple Lawn Homes, Inc.	100.00%	122,724		122,724	5
6	V	17 Administrative and General	387,571	Maple Lawn Homes, Inc.	100.00%			(387,571)	6
7	V	22 Employee Benefits		Maple Lawn Homes, Inc.	100.00%	145,102		145,102	7
8	V	26 Insurance		Maple Lawn Homes, Inc.	100.00%	1,159		1,159	8
9	V	30 Depreciation		Maple Lawn Homes, Inc.	100.00%	46,414		46,414	9
10	V	32 Interest		Maple Lawn Homes, Inc.	100.00%	2,496		2,496	10
11	V	33 Real Estate Tax		Maple Lawn Homes, Inc.	100.00%	527		527	11
12	V	43 Development		Maple Lawn Homes, Inc.	100.00%				12
13	V								13
14	Total		\$ 387,571			\$ 360,031	\$ *	(27,540)	14

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

Facility Name & ID Number      Maple Lawn Health Center      #      0042424      Report Period Beginning:      01-Jan-09      Ending:      31-Dec-09

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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-Jan-09 Ending: 31-Dec-09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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 6,457,534	3	\$ 21,072	\$	5,430,439	\$ 17,720	1
2	6	Maintenance	Accumulated Cost 6,457,534	3	13,642		5,430,439	11,472	2
3	19	Professional Service	Accumulated Cost 6,457,534	3	14,765		5,430,439	12,417	3
4	21	Supplies	Accumulated Cost 6,457,534	3	2,660		5,430,439	2,237	4
5	21	Administrative and General	Accumulated Cost 6,457,534	3	143,276	107,650	5,430,439	120,487	5
6	22	Employee Benefits	Accumulated Cost 6,457,534	3	172,546		5,430,439	145,102	6
7	26	Insurance - Prop. Liab.	Accumulated Cost 6,457,534	3	1,378		5,430,439	1,159	7
8	30	Depreciation	Accumulated Cost 6,457,534	3	55,192		5,430,439	46,414	8
9	32	Interest	Accumulated Cost 6,457,534	3	2,968		5,430,439	2,496	9
10	33	Real Estate Tax	Accumulated Cost 6,457,534	3	627		5,430,439	527	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				\$ 428,126	\$ 107,650		\$ 360,031	25

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01-Jan-09 Ending: 31-Dec-09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10
			Related**	YES				NO	Purpose of Loan				
								Original	Balance				
A. Directly Facility Related													
Long-Term													
1		FHA Mortgage # 1		X	Building	\$4,663.00	4/4/79	\$ 860,000	\$	4/4/11	5.000%	\$ 430.00	1
2		FHA Mortgage # 2		X	Building	\$6,300.00	7/7/89	900,000	255,727	7/7/14	6.500%	19,717.00	2
3		FHA Mortgage # 5		x	Building	\$1,779.00	08/01/04	400,000	327,350	Aug-34	4.125%	14,709.00	3
4		City of Eureka Bonds		X	Building	\$3,465.00	7/7/89	455,000	114,218	7/7/12	7.120%	8,759.00	4
5		FHA Mortgage # 4		X	Building	\$5,500.00	10/18/04	305,000	987,386	Oct-34	4.380%	45,263.00	5
Working Capital													
6		Heartland		X	Line of credit	varies	04/29/04	112,000	669,242	Apr-08	6.000%	44,094.00	6
7												-	7
8												-	8
9		TOTAL Facility Related				\$21,707.00		\$ 3,032,000	\$ 2,353,923			\$ 132,972	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	\$ 2,353,923			\$ 132,972	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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-Jan-09 Ending: 31-Dec-09

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

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill			
1.	Real Estate Tax accrual used on 2008 report.	\$	2,884	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.)	\$	2,665	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	(219)	3	
4.	Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	3,220	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.	\$	3,001	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2004	2,679	8	
		2005	2,734	9	
		2006	2,734	10	
		2007	2,734	11	
		2008	2,665	12	
* This entity is a 501(3)(c) organization paying R/E tax on a portion of the facility deemed taxable.					
C/Y accrual based on prior year tax paid.					
		<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2008	\$		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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 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 2008 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 2008.

(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>13-12-201-026</u>	<u>700 N. Main Street</u>	\$ <u>2,665</u>	\$ <u>2,665</u>
2. _____	<u>Beauty Shop</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>2,665.00</u>	\$ <u>2,665.00</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 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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-Jan-09 Ending: 31-Dec-09

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	<a href="#">Health Center</a>	<u>85,000</u>	<u>1965</u>	<u>\$ 1,386</u>	1
2	<a href="#">Health Center</a>	<u>39,000</u>	<u>1969</u>	<u>1,000</u>	2
3	TOTALS	<u>124,000</u>		<u>\$ 2,386</u>	3

Facility Name & ID Number Maple Lawn Health Center

# 0042424

Report Period Beginning:

01-Jan-09

Ending:

31-Dec-09

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	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		\$ 353,347	4
5			1974	1974	20,378	408	50	408		14,423	5
6			1980	1980	750,017	16,667	45	16,667		498,284	6
7			1982	1982	7,703		20			7,703	7
8	38		1989	1989	1,459,363	32,431	45	32,430	(1)	664,819	8
	Improvement Type**										
9		Landscaping		1982	1,155		20			1,155	9
10		Trees		1984	1,125		20			1,125	10
11		Trees		1984	1,976		20			1,976	11
12		Landscaping - Front of HC		1992	1,100		10			1,100	12
13		Asphalt Repair		1993	4,058		10			4,058	13
14		Parking Lot Lighting		1995	1,282		10			1,282	14
15		Asphalt Parking Lot		1995	2,528		10			2,528	15
16		ADU Enclosure		1995	4,305		10			4,305	16
17		Parking Blocks (20)		1996	654		10			654	17
18		Lower Level Renovation		1981	203,080		23			203,080	18
19		Lower Level Renovation		1982	35,963		22			35,963	19
20		Fixture Repairs & Refinish		1983	11,150		10			11,150	20
21		Trellis		1983	1,063		10			1,063	21
22		Loading Dock		1985	1,642		20			1,642	22
23		Deck		1992	2,574		10			2,574	23
24		Room Renovation		1992	1,067		10			1,067	24
25		Lobby Renovation		1993	32,583		10			32,583	25
26		Central Supply Room		1993	1,697		10			1,697	26
27		ADU Cabinets		1994	1,365		12			1,365	27
28		Wallpaper		1994	776		8			776	28
29		Wallpaper		1995	1,181		8			1,181	29
30		Wallpaper		1995	194		8			194	30
31		Carpet Room 702		1995	203		8			203	31
32		Wallcovering Admin Office		1995	732		8			732	32
33		Conference Room Wing 2		1995	512		8			512	33
34		Lobby Carpet		1996	19,386		10			19,386	34
35		Kitchen Ramp Floorcovering		1996	526		8			526	35
36		Room Renovating		1996	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 &amp; ID Number    Maple Lawn Health Center

#    0042424

Report Period Beginning:

01-Jan-09

Ending:

31-Dec-09

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Walk in Freezer	1975	\$ 2,853	\$	10	\$	\$	\$ 2,853		37
38	Sprinkler Installation	1976	11,240		20			11,240		38
39	Sprinkler Installation	1977	743		20			743		39
40	Generator	1980	9,500		20			9,500		40
41	Lite Fixture- Lobby	1982	4,634		20			4,634		41
42	Floor Covering Ramps Renovation	1982	1,116		10			1,116		42
43	Kitchen Air Vent	1982	650		20			650		43
44	Exhaust Fan	1984	2,800		20			2,800		44
45	Entrance Load Control	1985	13,672		15			13,672		45
46	Light Fixtures	1985	936		10			936		46
47	Water Softner	1987	699		5			699		47
48	Alarm System	1989	5,473		15			5,473		48
49	Wander Guard System	1990	7,685		8			7,685		49
50	Door Alarms	1990	1,461		8			1,461		50
51	Garbage Disposal	1990	951		10			951		51
52	Air Conditioning Condenser	1990	2,395		15			2,395		52
53	Air Conditioning Unit	1991	3,105	155	20	155		2,871		53
54	Management System (5 Units)	1991	1,163		15			1,163		54
55	Privacy Curtains	1991	11,200		10			11,200		55
56	Water heater Tanks	1992	12,622		15			12,622		56
57	Century Whirlpool Tub	1993	3,284		15			3,284		57
58	Laundry Machine Motor	1993	515		30			515		58
59	Assembly Room Sound System	1993	1,410		15			1,410		59
60	Wander Guard Door Monitor	1993	1,212		8			1,212		60
61	MTCO Telephone System	1993	12,883		10			12,883		61
62	Paging System	1994	707		3			707		62
63	ADU Door Monitoring System	1994	914		3			914		63
64	Upgrade Elevator	1994	3,298		10			3,298		64
65	Air Conditioning -Dining Room	1994	1,723		20	86	86	1,320		65
66	Hatco Toaster	1995	980		10			980		66
67	Fiber Optics Wiring	1995	4,645		5			4,645		67
68	Dining Room A/C Unit	1995	3,187	159	20	159		2,335		68
69	Wood Graphics Signs	1995	1,131		7			1,131		69
70	TOTAL (lines 4 thru 69)		\$ 3,175,094	\$ 57,687		\$ 57,772	\$ 85	\$ 2,002,720		70

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

Facility Name &amp; ID Number      Maple Lawn Health Center

#      0042424

Report Period Beginning:

01-Jan-09

Ending:

31-Dec-09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,175,094	\$ 57,687		\$ 57,772	\$ 85	\$ 2,002,720	1
2	Kitchen Shelves / Counter	1995	6,667	444	15	444		6,316	2
3	Parker Bath	1995	8,598		10			8,598	3
4	Magnetic Door Lock System	1996	2,846		10			2,846	4
5	Service Sink	1996	656		10			656	5
6	Nurse Call System	1996	21,777		10			21,777	6
7	A/C Unit -Central Supply Room	1996	3,515		10			3,515	7
8	Elevator Upgrade	1996	13,117		10			13,117	8
9	A/C Unit Laundry Room	1996	5,986		10			5,986	9
10	A/C Unit Kitchen	1996	5,688		10			5,688	10
11	Alarm System	1996	709		8			709	11
12	Tektone Door Alarm	1996	673		8			673	12
13	Vertical Blinds	1994	1,021		8			1,021	13
14	Landscaping	1997	3,116		10			3,116	14
15	Remodel Smoking Area	1997	553		10			553	15
16	Patient Room Renovation	1997	979		8			979	16
17	Lobby Renovation	1997	499		9			499	17
18	Sink & Counter for Empl.Lounge	1997	1,319		8			1,319	18
19	Fireplace Conversion	1997	2,762		10			2,762	19
20	Kitchen Waterline Replacement	1997	1,591		10			1,591	20
21	Chapel Renovation	1997	17,045		10			17,045	21
22	Nurse Call System Cords	1997	588		5			588	22
23	Addressable Fire alarm System	1997	11,790		10			11,790	23
24	Fire Alarm Annunciator	1997	985		10			985	24
25	Expansion Tank	1997	3,800		8			3,800	25
26	Door Security Upgrade	1997	2,843		10			2,843	26
27	Phone System Additions	1997	821		10			821	27
28	Bathtub	1997	6,080		10			6,080	28
29	Bath Lift	1997	3,294		10			3,294	29
30	Parking Lot Repair	1998	1,829		10			1,829	30
31	Landscaping	1998	700		10			700	31
32	Boiler Repairs	1998	2,415		10			2,415	32
33	Automatic Door	1998	3,651		10			3,651	33
34	TOTAL (lines 1 thru 33)		\$ 3,313,007	\$ 58,131		\$ 58,216	\$ 85	\$ 2,140,282	34

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

## STATE OF ILLINOIS

Page 12C

Facility Name &amp; ID Number      Maple Lawn Health Center

#

0042424

Report Period Beginning:

01-Jan-09

Ending:

31-Dec-09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	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	\$ 58,131		\$ 58,216	\$ 85	\$ 2,140,282	1
2	Wing 3 Renovation	1998	2,825		10			2,825	2
3	Dining Room Renovation	1998	13,665		10			13,665	3
4	Hall 3 Fire Detectors	1998	1,794		8			1,794	4
5	Hall 2 Fire Detectors	1998	2,994		8			2,994	5
6	Emergency Generator Repairs	1998	1,356		10			1,356	6
7	Free Standing Bath	1998	8,958		10			8,958	7
8	Security System/ADU Outdoor Gate	1998	1,127		8			1,127	8
9	Cable System	1998	24,353		5			24,353	9
10	A/C Lower Lobby - By Dining Rm	1998	3,604		10	2	2	3,604	10
11	Asphalt Repair	1999	2,467	164	10	163	(1)	2,467	11
12	Dining Room Renovation	1999	1,428		10	34	34	1,428	12
13	Hall 6 Renovation	1999	2,588	172	10	172		2,588	13
14	New Door for Entrance	1999	2,665	222	10	220	(2)	2,665	14
15	Hall 7 Renovation	1999	6,647	609	10	608	(1)	6,647	15
16	Bath Flooring	1999	2,018		8			2,018	16
17	Janitor Floor	1999	326		8			326	17
18	Hall 1 Renovation	1999	2,276		8			2,276	18
19	Electronic Eye Door-Main Entrance	1999	3,723	30	10	372	342	3,721	19
20	Office Renovation	1999	2,458	21	10	245	224	2,458	20
21	Lounge Renovation	1999	927	7	10	91	84	927	21
22	Door alarms Halls 1 & 3	1999	4,285		8			4,285	22
23	Fire Alarms Halls 1,6,7	1999	5,290		8			5,290	23
24	A/C Condensor	1999	1,001		10	50	50	1,001	24
25	Adjustable Sink	1999	2,569		8			2,569	25
26	Carousel Whirlpool	1999	16,897	140	10	1,688	1,548	16,897	26
27	Heating A/C Unit Hall 6	1999	998		10	99	99	998	27
28	Asphalt Repair	2000	2,352	235	10	235		2,174	28
29	Tempered Water System Redesigned	2000	14,400	720	20	720		6,960	29
30	Renovate Social Service Office	2000	3,422	342	10	342		3,278	30
31	Wanderguard Monitors	2000	2,591		8			2,591	31
32	New Boiler in Cleveland Steamer	2000	4,076	408	10	408		3,773	32
33	Octel 100 Voicemail System	2000	6,260		5			6,260	33
34	TOTAL (lines 1 thru 33)		\$ 3,465,347	\$ 61,201		\$ 63,665	\$ 2,464	\$ 2,284,555	34

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

Facility Name &amp; ID Number      Maple Lawn Health Center

#

0042424

Report Period Beginning:

01-Jan-09

Ending:

31-Dec-09

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	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	\$ 61,201		\$ 63,665	\$ 2,464	\$ 2,284,555		1
2	Cable System Expansion	2000	1,844		5			1,844		2
3	Land Improve- Sidewalk Replacement	2001	485	48	10	49	1	395		3
4	Water System Installation	2001	41,500	2,075	20	2,075		18,502		4
5	Administrative Office - Carpet	2001	1,447	45	8	45		1,447		5
6	Fire Alarms- Halls 4 & 5	2001	6,436		8			6,436		6
7	Air Condition Unit Hall 6	2001	3,424	342	10	342		2,937		7
8	Door Alarms - Hall 7	2001	2,757	258	8	257	(1)	2,757		8
9	Elevator Safety Edges	2002	3,245	324	10	325	1	2,464		9
10	Reshingle - Memorial Hall	2002	739	37	20	37		271		10
11	A/C Condensor - HC Lobby	2002	785		10	79	79	585		11
12	Cable System Upgrade	2002	1,138		5			1,138		12
13	Sandblasted Redwood Signs	2002	736	96	7	97	1	736		13
14	Room 601 Construction	2003	34,315	1,716	20	1,716		11,440		14
15	Room 306 Bathroom Conversion	2003	21,425	2,142	10	2,143	1	14,286		15
16	PT Room Divider Curtain	2003	2,589	259	10	259		1,727		16
17	Crosslink II Traverline Carpet	2003	936	117	8	117		780		17
18	Insinkerator Disposer for Kitchen	2003	1,048		5			1,048		18
19	New Exit Doors & Keypads	2003	9,618	1,374	7	1,374		8,702		19
20	New Parking Lot	2003	9,378	782	12	782		5,148		20
21	Wallpaper -Rm 302/Hall#1/Dining Rm	2003	542	77	7	77		507		21
22	Wallpaper Stock for Room Renovations	2003	600		7	86	86	566		22
23	Asbestos removal - Dining Rm Floor	2003	10,520	1,503	7	1,503		9,519		23
24	Vinyl Flooring in Dining Rm	2003	12,700	1,814	7	1,814		11,489		24
25	Wallpaper Hall 2	2004	700	100	7	100		587		25
26	Expansion Dining Room	2004	2,612	174	15	174		1,021		26
27	Flooring for Elevator	2004	1,479	185	8	185		1,005		27
28	Walk-in Cooler	2004	8,043	804	10	804		4,657		28
29	Door Lock	2004	3,313	474	7	473	(1)	2,737		29
30	Telephone System	2004	16,115	1,612	10	1,612		9,177		30
31	Draperies	2004	733	105	7	105		618		31
32	Draperies	2004	974	139	7	139		793		32
33	Sealcoat Parking Lot	2004	2,479		3			2,479		33
34	TOTAL (lines 1 thru 33)		\$ 3,670,002	\$ 77,803		\$ 80,434	\$ 2,631	\$ 2,412,353		34

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

Facility Name &amp; ID Number Maple Lawn Health Center

#

0042424

Report Period Beginning:

01-Jan-09

Ending:

31-Dec-09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	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	\$ 77,803		\$ 80,434	\$ 2,631	\$ 2,412,353	1
2	Landscaping	2004	2,778	278	10	278		1,521	2
3	Renovation on resident rooms, hallways	2005	670,114	22,942	30	22,337	(605)	111,624	3
4	Roof replacement	2005	414,304	13,810	30	13,810		69,012	4
5	Resident room doors and refinishing	2005	6,164	205	30	205		929	5
6	Carpet and Tile Flooring	2005	39,119	2,608	15	2,608		11,747	6
7	Wallpaper for lobby	2005	3,921	392	10	392		1,766	7
8	Sprinkler system	2005	71,880	2,396	30	2,396		11,973	8
9	Lighting resident rooms and lobby.	2005	4,754	159	30	158	(1)	716	9
10	Time clock system	2005	34,290	3,429	10	3,429		15,445	10
11	Privacy track, window rods, draperies	2005	5,678	717	7	811	94	4,053	11
12	Carpeting room 608	2005	758	95	8	95		451	12
13	Wiring Upgrade	2005	1,498	300	5	300		1,478	13
14	A/C condenser replacement	2005	4,775	318	15	318		1,459	14
15	Boiler replacement	2005	4,495	450	10	450		2,112	15
16	Asphalt Repairs	2005	1,200	240	5	240		1,081	16
17	Renovate Multi-Rm/Nurse Station	2005	85,586	2,852	30	2,853	1	12,850	17
18	Roof Replacement Dietary	2005	14,503	483	30	483		2,137	18
19	Nurse Station Bumper Guards	2005	491	98	5	98		431	19
20	Chimney roofing work	2005	2,180	109	20	109		472	20
21	Install sink	2005	1,345	90	15	90		383	21
22	Transfer switch	2005	2,549	364	7	364		1,650	22
23	Sprinkler system	2005	934	31	30	31		140	23
24	Air conditioning unit	2005	3,300	220	15	220		949	24
25	Sprinkler head	2005	1,458	49	30	49		198	25
26	Gas shut-off fire system	2005	2,600	87	30	87		377	26
27	Fire alarm	2005	11,087	739	15	739		3,108	27
28	Boiler pump	2005	3,986	399	10	399		1,613	28
29	Door	2006	1,379	138	10	138		437	29
30	Plumbing	2006	1,023	102	10	102		340	30
31	Carpeting	2006	2,618	262	10	262		1,026	31
32	Draperies	2006	174	25	7	25		98	32
33	Dining room wallpaper, lighting	2007	3,531	191	8	441	250	1,279	33
34	TOTAL (lines 1 thru 33)		\$ 5,074,474	\$ 132,381		\$ 134,751	\$ 2,370	\$ 2,675,208	34

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

Facility Name &amp; ID Number Maple Lawn Health Center

#

0042424

Report Period Beginning:

01-Jan-09

Ending:

31-Dec-09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	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	\$ 132,381		\$ 134,751	\$ 2,370	\$ 2,675,208	1
2	Public address system	2007	461	92	5	92		241	2
3	Asphalt road repairs	2007	18,979	1,265	15	1,265		3,372	3
4	Room 701 flooring, lighting	2007	1,371	180	8	171	(9)	457	4
5	Sidewalk repairs	2007	3,054	328	10	305	(23)	778	5
6	Room 707 flooring, cabinetry	2007	1,208	148	8	151	3	388	6
7	Carpeting room 709	2007	591	74	8	74		174	7
8	Room 603 wallpaper, window coverings, lighting	2007	815	4	8	102	98	221	8
9	Room 612, lighting, flooring	2007	673	84	8	84		182	9
10	Room 604 window coverings	2007	55		1			55	10
11	Wallcoverings hall and 4 rooms	2007	1,400	175	8	175		372	11
12	Gate concrete pad	2007	725	242	3	242		504	12
13	Plumbing wing 1	2007	2,500	312	8	313	1	647	13
14	Fire alarm system upgrade	2007	4,150	100	8	519	419	1,062	14
15	Driveway curbing	2008	3,300	220	15	220		360	15
16	Plumbing, lighting, wallpaper	2008	7,686	837	8	961	124	1,885	16
17	Carpeting and door replacement	2008	1,200	140	8	150	10	294	17
18	Fireproofing and sprinklers	2008	33,288	1,491	15	2,219	728	4,128	18
19	Drainage work	2008	3,460	173	15	231	58	405	19
20	Eyewash station in kitchen	2008	1,250	104	8	156	52	264	20
21	Baseboards, wallpaper, carpeting	2008	1,825	96	10	183	87	320	21
22	Air conditioning repairs	2008	6,800	337	8	850	513	1,253	22
23	Elevator repairs	2008	1,206	201	3	402	201	602	23
24	Emergency exit lighting	2008	1,394	58	8	174	116	233	24
25	Bath tub fixture	2008	729	4	15	49	45	52	25
26	Wing 1 & Hall 1 draperies, wallpaper, lighting	2008	7,328	1,077	8	916	(161)	1,792	26
27	Draperies, wallpaper, & baseboards	2008	7,251	688	8	906	218	1,778	27
28	Contractor labor & materials for dining room	2008	12,087	1,133	8	1,511	378	2,964	28
29	Dining room tear-down, tiling, painting, trim	2008	5,716	714	8	715	1	1,402	29
30	Gazebo shingles & vinyl	2009	372	24	7	22	(2)	22	30
31	Chapel fans, shades, ceiling tile & fixtures	2009	8,273	454	5	802	348	802	31
32	Flooring for rooms 705, 605, 609	2009	1,915	64	10	23	(41)	23	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,215,536	\$ 143,200		\$ 148,734	\$ 5,534	\$ 2,702,240	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-Jan-09

Ending:

31-Dec-09

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,215,536	\$ 143,200		\$ 148,734	\$ 5,534	\$ 2,702,240	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,215,536	\$ 143,200		\$ 148,734	\$ 5,534	\$ 2,702,240	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-Jan-09

Ending:

31-Dec-09

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,215,536	\$ 143,200		\$ 148,734	\$ 5,534	\$ 2,702,240	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,215,536	\$ 143,200		\$ 148,734	\$ 5,534	\$ 2,702,240	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-Jan-09

Ending:

31-Dec-09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 5,215,536	\$ 143,200		\$ 148,734	\$ 5,534	\$ 2,702,240	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,215,536	\$ 143,200		\$ 148,734	\$ 5,534	\$ 2,702,240	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 147,645	\$ 30,311	\$ 30,311	\$	various	\$ 272,200	71
72	Current Year Purchases	1,683	309	309		various	309	72
73	Fully Depreciated Assets	249,519				various	249,519	73
74								74
75	TOTALS	\$ 398,847	\$ 30,620	\$ 30,620	\$		\$ 522,028	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	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)	\$ 5,625,823	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,820	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,354	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,534	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,233,322	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	\$ 480	\$ 14,413	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 21,141	\$ 480	\$ 14,413	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$	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.

**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	<b>TOTAL</b>				\$			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.	_____ /2010	\$ _____
13.	_____ /2011	\$ _____
14.	_____ /2012	\$ _____

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: \$ 1,113

Description: Copter

(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	<b>TOTAL</b>		\$	\$	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: 01-Jan-09 Ending: 31-Dec-09  
 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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.



STATE OF ILLINOIS

Facility Name & ID Number Maple Lawn Health Center

# 0042424

Report Period Beginning: 01-Jan-09

Ending:

31-Dec-09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 206,811	\$	1
2	Cash-Patient Deposits	7,010		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (83,348) )	928,283		3
4	Supply Inventory (priced at FIFO )	28,787		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,872		6
7	Other Prepaid Expenses	1,992		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R Other</u>	709,408		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,827,815	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	146,001		12
13	Land	2,386		13
14	Buildings, at Historical Cost	4,499,836		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	775,041		16
17	Accumulated Depreciation (book methods)	(2,705,963)		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>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,717,301	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,545,116	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 404,085	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,010		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,977		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,220		32
33	Accrued Interest Payable	3,022		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Accrued Expenses</u>	271,358		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 853,672	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	2,353,923		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)	\$ 2,353,923	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,207,595	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,337,521	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,545,116	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		I Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,177,246	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	116,225	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,293,471	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	44,050	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)	\$ 44,050	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 1,337,521	24 *

\* This must agree with page 17, line 47.

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Maple Lawn Health Center

# 0042424

Report Period Beginning: 01-Jan-09

Ending: 31-Dec-09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,112,752	1
2	Discounts and Allowances for all Levels	(1,746,597)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,366,155	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	776,310	6
7	Oxygen	6,924	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 783,234	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	361	12
13	Barber and Beauty Care	3,322	13
14	Non-Patient Meals	80,240	14
15	Telephone, Television and Radio	8,927	15
16	Rental of Facility Space		16
17	Sale of Drugs	54,224	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,227	19
20	Radiology and X-Ray	1,459	20
21	Other Medical Services	68,156	21
22	Laundry	150	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 224,066	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	68,795	24
25	Interest and Other Investment Income***	1,014	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 69,809	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Admission Fee	2,000	28
28a	Miscellaneous	29,225	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,225	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,474,489	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,075,679	31
32	Health Care	2,250,943	32
33	General Administration	1,666,296	33
<b>B. Capital Expense</b>			
34	Ownership	311,385	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	73,535	35
36	Provider Participation Fee	52,601	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,430,439	40
41	Income before Income Taxes (line 30 minus line 40)**	44,050	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 44,050	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-Jan-09

Ending:

31-Dec-09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,024	2,080	\$ 72,233	\$ 34.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,392	11,012	227,479	20.66	3
4	Licensed Practical Nurses	16,616	17,642	346,537	19.64	4
5	CNAs & Orderlies	64,403	68,091	878,830	12.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,737	4,072	49,206	12.08	8
9	Activity Director	1,968	2,080	32,131	15.45	9
10	Activity Assistants	2,399	2,640	23,710	8.98	10
11	Social Service Workers	5,023	5,296	81,172	15.33	11
12	Dietician	1,520	1,654	27,477	16.61	12
13	Food Service Supervisor	3,940	4,250	42,379	9.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,048	22,411	230,448	10.28	15
16	Dishwashers					16
17	Maintenance Workers	1,931	2,107	46,078	21.87	17
18	Housekeepers	9,645	10,375	122,325	11.79	18
19	Laundry	2,612	2,462	19,968	8.11	19
20	Administrator	1,344	1,489	56,752	38.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,952	2,120	40,858	19.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>ETO</u>			147,629		33
34	TOTAL (lines 1 - 33)	150,554	159,781	\$ 2,445,212 *	\$ 15.30	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	51	7,700	9.3	36
37	Medical Records Consultant	30	1,800	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	31	2,304	10.3	39
40	Physical Therapy Consultant	20	1,268	10a.3	40
41	Occupational Therapy Consultant	28	1,794	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	31	1,883	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)	191	\$ 16,749		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	155	\$ 5,742	10.3	50
51	Licensed Practical Nurses	381	12,426	10.3	51
52	Certified Nurse Assistants/Aides			10.3/10a.3	52
53	TOTAL (lines 50 - 52)	536	\$ 18,168		53

Facility Name & ID Number Maple Lawn Health Center

# 0042424

Report Period Beginning:

01-Jan-09

Ending: 31-Dec-09

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
John Koehler	Administrator		\$ 56,752	Workers' Compensation Insurance	\$ 306,873	IDPH License Fee	\$		
				Unemployment Compensation Insurance	8,413	Advertising: Employee Recruitment	29,578		
				FICA Taxes	186,475	Health Care Worker Background Check	1,010		
				Employee Health Insurance	176,994	(Indicate # of checks performed <u>101</u> )			
				Employee Meals		Patient Background Checks	93		
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of IL	4,854		
See attached sch				Employee Pension Plan	26,786	Mennonite Health Services	9,769		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 56,752	Employee Life/Disability	7,835	Dues & Licenses	1,601		
(List each licensed administrator separately.)				Employee Uniforms		Subscriptions & Newspapers	5,452		
B. Administrative - Other				Employee Physicals, Hep. B.	18,907	Rounding			
Description			Amount	Employee Appreciation	18,963	Less: Public Relations Expense	( )		
			\$	Maple Lawn Homes, Inc. Alloc.	145,102	Non-allowable advertising	(1,411)		
				Rounding	2	Yellow page advertising	(3,794)		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 896,350	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 47,989		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services							Out-of-State Travel	\$	
Vendor/Payee	Type		Amount						
McGladrey & Pullen	Accounting		\$ 54,413				In-State Travel	1,238	
Robert Rein	Consulting		6,222						
Foley & Lardner	Life Safety Code Survey		5,968				Seminar Expense	2,222	
Poisinell, Shalton	Legal		2,498						
Alliance Benefit Group	Section 125 Administration		2,010				Entertainment Expense	( )	
Howard & Howard	Legal		775				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,460	
Reclassifications									
FRR	Consulting		675						
Farnsworth	Consulting		3,006						
	rounding		1						
See attached sch				TOTAL		\$			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 75,568						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Maple Lawn Health Center# 0042424Report Period Beginning: 01-Jan-09Ending: 31-Dec-09

31-Dec-09

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network of IL 4,854
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,710 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,728  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 80,240
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
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. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen
- (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.