

		FOR REFUSE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

<p>I. IDPH License ID Number: <u>0042424</u></p> <p>Facility Name: <u>Maple Lawn Health Center</u></p> <p>Address: <u>700 N. Main Street</u> <u>Eureka</u> <u>61530</u> <small>Number City Zip Code</small></p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 467-2337</u> Fax # <u>(309) 467-9097</u></p> <p>HFS ID Number: <u>37-0681536001</u></p> <p>Date of Initial License for Current Owners: <u>1922</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jeff Corron</u> Telephone Number: <u>(309) 467-2337</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2010</u> to <u>12/31/2010</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Jeff Corron</u> (Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>ROBERT REIN, CPA</u> (Firm Name & Address) <u>PO BOX 201, MORTON, IL 61550-0201</u> (Telephone) <u>(309) 266-8178</u> Fax # () _____</td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jeff Corron</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>ROBERT REIN, CPA</u> (Firm Name & Address) <u>PO BOX 201, MORTON, IL 61550-0201</u> (Telephone) <u>(309) 266-8178</u> Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jeff Corron</u> (Title) <u>Chief Financial Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>ROBERT REIN, CPA</u> (Firm Name & Address) <u>PO BOX 201, MORTON, IL 61550-0201</u> (Telephone) <u>(309) 266-8178</u> Fax # () _____							

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	290,753	22,728		313,481		313,481		313,481		1
2	Food Purchase		308,456		308,456		308,456	(88,136)	220,320		2
3	Housekeeping	147,627	17,181	2,961	167,769		167,769		167,769		3
4	Laundry	20,359	15,736		36,095		36,095		36,095		4
5	Heat and Other Utilities			116,209	116,209		116,209	13,559	129,768		5
6	Maintenance	57,274	9,990	90,503	157,767	(477)	157,290	(4,718)	152,572		6
7	Other (specify):*										7
8	TOTAL General Services	516,013	374,091	209,673	1,099,777	(477)	1,099,300	(79,295)	1,020,005		8
	B. Health Care and Programs										
9	Medical Director			7,700	7,700		7,700		7,700		9
10	Nursing and Medical Records	1,597,603	113,296	155,822	1,866,721		1,866,721		1,866,721		10
10a	Therapy	53,843	2,361	307,527	363,731		363,731		363,731		10a
11	Activities	64,801	2,927	6,725	74,453		74,453		74,453		11
12	Social Services	77,216	1,346	1,068	79,630		79,630		79,630		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,793,463	119,930	478,842	2,392,235		2,392,235		2,392,235		16
	C. General Administration										
17	Administrative	76,602		404,568	481,170		481,170	(404,568)	76,602		17
18	Directors Fees										18
19	Professional Services			59,056	59,056	(360)	58,696	12,753	71,449		19
20	Dues, Fees, Subscriptions & Promotions			26,521	26,521	655	27,176	(4,953)	22,223		20
21	Clerical & General Office Expenses	190,498	18,669	336,947	546,114	1,358	547,472	350,436	897,908		21
22	Employee Benefits & Payroll Taxes			631,475	631,475		631,475	71,729	703,204		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,523	8,523		8,523		8,523		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,642	77,642	360	78,002	145	78,147		26
27	Other (specify):*										27
28	TOTAL General Administration	267,100	18,669	1,544,732	1,830,501	2,013	1,832,514	25,542	1,858,056		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,576,576	512,690	2,233,247	5,322,513	1,536	5,324,049	(53,753)	5,270,296		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:

01/01/2010

Ending:

12/31/2010

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			172,353	172,353		172,353	59,005	231,358			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,527	128,527		128,527	9,546	138,073			32
33	Real Estate Taxes			1,938	1,938		1,938	(1)	1,937			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,113	1,113	477	1,590		1,590			35
36	Other (specify):*											36
37	TOTAL Ownership			303,931	303,931	477	304,408	68,550	372,958			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,823		42,823		42,823		42,823			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,728	48,728	(2,013)	46,715		46,715			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		42,823	48,728	91,551	(2,013)	89,538		89,538			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,576,576	555,513	2,585,906	5,717,995		5,717,995	14,797	5,732,792			45

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

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	(87,501)	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	523	30.3		9
10	Interest and Other Investment Income	(969)	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	(31,103)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (119,050)		\$	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)	133,847		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 133,847		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 14,797		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			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			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.	100.00%			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 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	5 Utilities	\$ -	Maple Lawn Homes, Inc.	100.00%	\$ 13,559	\$ 13,559	1
2	V	6 Maintenance	-	Maple Lawn Homes, Inc.	100.00%	2,369	2,369	2
3	V	12 Social Services	-	Maple Lawn Homes, Inc.	100.00%	-	-	3
4	V	19 Professional Service	-	Maple Lawn Homes, Inc.	100.00%	12,753	12,753	4
5	V	21 Administrative and General	-	Maple Lawn Homes, Inc.	100.00%	357,365	357,365	5
6	V	17 Administrative and General	404,568	Maple Lawn Homes, Inc.	100.00%	-	(404,568)	6
7	V	22 Employee Benefits	-	Maple Lawn Homes, Inc.	100.00%	71,729	71,729	7
8	V	26 Insurance	-	Maple Lawn Homes, Inc.	100.00%	145	145	8
9	V	30 Depreciation	-	Maple Lawn Homes, Inc.	100.00%	58,962	58,962	9
10	V	32 Interest	-	Maple Lawn Homes, Inc.	100.00%	10,515	10,515	10
11	V	33 Real Estate Tax	-	Maple Lawn Homes, Inc.	100.00%	11,018	11,018	11
12	V	43 Development	-	Maple Lawn Homes, Inc.	100.00%	-	-	12
13	V							13
14	Total		\$ 404,568			\$ 538,415	\$ * 133,847	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:

01/01/2010

Ending:

12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization						
15	V			\$				\$		\$	15
16	V										16
17	V										17
18	V										18
19	V										19
20	V										20
21	V										21
22	V										22
23	V										23
24	V										24
25	V										25
26	V										26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$				\$	0	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Maple Lawn Health Center

0042424 Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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	7,440,543	3	\$ 17,644	\$ 5,717,995	\$ 13,559	1
2	6	Maintenance	Accumulated Cost	7,440,543	3	3,083	5,717,995	2,369	2
3	19	Professional Service	Accumulated Cost	7,440,543	3	16,595	5,717,995	12,753	3
4	21	Supplies	Accumulated Cost	7,440,543	3	15,902	5,717,995	12,221	4
5	21	Administrative and General	Accumulated Cost	7,440,543	3	449,119	424,272	345,144	5
6	22	Employee Benefits	Accumulated Cost	7,440,543	3	93,337	5,717,995	71,729	6
7	26	Insurance - Prop. Liab.	Accumulated Cost	7,440,543	3	189	5,717,995	145	7
8	30	Depreciation	Accumulated Cost	7,440,543	3	76,724	5,717,995	58,962	8
9	32	Interest	Accumulated Cost	7,440,543	3	13,683	5,717,995	10,515	9
10	33	Real Estate Tax	Accumulated Cost	7,440,543	3	14,337	5,717,995	11,018	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					\$ 700,613	\$ 424,272	\$ 538,415	25

Facility Name & ID Number Maple Lawn Health Center

0042424 Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	0

Facility Name & ID Number

Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1					-		\$				-	\$	1					
2	FHA Mortgage # 2		X	Building	6,300	7/7/89		900,000	194,957	7/7/14	0.0650		14,591	2				
3	FHA Mortgage # 5		x	Building	1,779	Aug-04		400,000	319,355	Aug-34	0.0413		13,329	3				
4	City of Eureka Bonds		X	Building	3,465	7/7/89		455,000	91,545	7/7/12	0.0712		5,675	4				
5	FHA Mortgage # 4		X	Building	5,500	Oct-04		305,000	964,119	Oct-34	0.0438		42,700	5				
	Working Capital																	
6	Heartland		X	Line of credit	varies	Apr-04		112,000	761,647	Apr-08	0.0600		52,232	6				
7											-			7				
8											-			8				
9	TOTAL Facility Related				\$17,044.00		\$	2,172,000	\$ 2,331,623			\$	128,527	9				
	B. Non-Facility Related*																	
10											-			10				
11											-			11				
12											-			12				
13											-			13				
14	TOTAL Non-Facility Related						\$		\$			\$		14				
15	TOTALS (line 9+line14)						\$	2,172,000	\$ 2,331,623			\$	128,527	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.		\$	3,220	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.)		\$	2,722			2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	(498)			3																			
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	2,435			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.		\$	1,937			7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2005	2,734	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2009	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2006	2,734	9																						
	2007	2,734	10																						
	2008	2,665	11																						
	2009	2,722	12																						
* This entity is a 501(3)(c) organization paying R/E tax on a portion of the facility deemed taxable.																									
<u>C/Y accrual based on prior year tax paid.</u>																									

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: 2009 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 2009 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2009.

Please complete the Real Estate Tax Statement below and include it in the 2010 cost report along with a copy of your 2009 real estate tax bill.

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.

2009 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 Jeff Corron
 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 2009 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 2009.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. <u>13-12-201-026</u>	<u>700 N. Main Street</u>	\$ <u>2,722</u>	\$ <u>2,722</u>
2. _____	<u>Beauty Shop</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>2,722</u>	\$ <u>2,722</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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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:

01/01/2010 Ending:

12/31/2010

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		\$ 361,214	4
5			1974	1974	20,378	408	50	408		14,831	5
6			1980	1980	750,017	16,667	45	16,667		514,951	6
7			1982	1982	7,703		20			7,703	7
8	38		1989	1989	1,459,363	32,431	45	32,430	(1)	697,249	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	155	20	234	79	15,468	35
36		Water heater Tanks		1992	12,622		15			12,622	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Tub,Motor,Sound Sys,Wander Guard,Tele Sys	1993	\$ 19,304	\$	10	\$	\$	19,304	37
38	Paging Sys,Door Monitor,elevator,A/C	1994	6,642		10	403	403	6,642	38
39	Toaster,Fiber Optics,A/C,Signage,Counter,Bath	1995	25,208	529	10	1,203	674	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,Parking	1998	69,271		10			69,271	44
45	Asphalt,DiningRm,Hall,Door,Bath,ElecEye	1999	24,138		10	2	2	24,138	45
46	Office,Lounge,Door,Fire,A/C,Sink,Tub	1999	34,425		10			34,425	46
47	Asphalt Repair	2000	2,352	176	10	178	2	2,352	47
48	Tempered Water System Redesigned	2000	14,400	720	20	720		7,680	48
49	Renovate Social Service Office	2000	3,422	342	10	144	(198)	3,422	49
50	Wanderguard Monitors	2000	2,591		8			2,591	50
51	New Boiler in Cleveland Steamer	2000	4,076	306	10	303	(3)	4,076	51
52	Octel 100 Voicemail System	2000	6,260		5			6,260	52
53	Cable System Expansion	2000	1,844		5			1,844	53
54	Land Improve- Sidewalk Replacement	2001	485	48	10	49	1	444	54
55	Water System Installation	2001	41,500	2,075	20	2,075		20,577	55
56	Administrative Office - Carpet	2001	1,447		8			1,447	56
57	Fire Alarms- Halls 4 & 5	2001	6,436		8			6,436	57
58	Air Condition Unit Hall 6	2001	3,424	342	10	342		3,279	58
59	Door Alarms - Hall 7	2001	2,757		8			2,757	59
60	Elevator Safety Edges	2002	3,245	324	10	325	1	2,789	60
61	Reshingle - Memorial Hall	2002	739	37	20	37		308	61
62	A/C Condensor - HC Lobby	2002	785		10	79	79	664	62
63	Cable System Upgrade	2002	1,138		5			1,138	63
64	Sandblasted Redwood Signs	2002	736		7			736	64
65	Room 601 Construction	2003	34,315	1,716	20	1,716		13,156	65
66	Room 306 Bathroom Conversion	2003	21,425	2,142	10	2,143	1	16,429	66
67	PT Room Divider Curtain	2003	2,589	259	10	259		1,986	67
68	Crosslink II Traverline Carpet	2003	936	117	8	117		897	68
69	Insinkerator Disposer for Kitchen	2003	1,048		5			1,048	69
70	TOTAL (lines 4 thru 69)		\$ 3,590,196	\$ 66,661		\$ 67,701	\$ 1,040	\$ 2,421,049	70

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,590,196	\$ 66,661		\$ 67,701	\$ 1,040	\$ 2,421,049	1
2	New Exit Doors & Keypads	2003	9,618	916	7	916		9,618	2
3	New Parking Lot	2003	9,378	782	12	782		5,930	3
4	Wallpaper -Rm 302/Hall#1/Dining Rm	2003	542	32	7	35	3	542	4
5	Wallpaper Stock for Room Renovations	2003	600		7	34	34	600	5
6	Asbestos removal - Dining Rm Floor	2003	10,520	1,002	7	1,001	(1)	10,520	6
7	Vinyl Flooring in Dining Rm	2003	12,700	1,210	7	1,211	1	12,700	7
8	Wallpaper Hall 2	2004	700	100	7	100		687	8
9	Expansion Dining Room	2004	2,612	174	15	174		1,195	9
10	Flooring for Elevator	2004	1,479	185	8	185		1,190	10
11	Walk-in Cooler	2004	8,043	804	10	804		5,461	11
12	Door Lock	2004	3,313	474	7	473	(1)	3,210	12
13	Telephone System	2004	16,115	1,612	10	1,612		10,789	13
14	Draperies	2004	733	105	7	105		723	14
15	Draperies	2004	974	139	7	139		932	15
16	Sealcoat Parking Lot	2004	2,479		3			2,479	16
17	Landscaping	2004	2,778	278	10	278		1,799	17
18	Renovation on resident rooms, hallways	2005	670,114	22,942	30	22,337	(605)	133,961	18
19	Roof replacement	2005	414,304	13,810	30	13,810		82,822	19
20	Resident room doors and refinishing	2005	6,164	205	30	205		1,134	20
21	Carpet and Tile Flooring	2005	39,119	2,608	15	2,608		14,355	21
22	Wallpaper for lobby	2005	3,921	392	10	392		2,158	22
23	Sprinkler system	2005	71,880	2,396	30	2,396		14,369	23
24	Lighting resident rooms and lobby.	2005	4,754	159	30	158	(1)	874	24
25	Time clock system	2005	34,290	3,429	10	3,429		18,874	25
26	Privacy track, window rods, draperies	2005	5,678	717	7	811	94	4,864	26
27	Carpeting room 608	2005	758	95	8	95		546	27
28	Wiring Upgrade	2005	1,498	25	5	20	(5)	1,498	28
29	A/C condenser replacement	2005	4,775	318	15	318		1,777	29
30	Boiler replacement	2005	4,495	450	10	450		2,562	30
31	Asphalt Repairs	2005	1,200	120	5	119	(1)	1,200	31
32	Renovate Multi-Rm/Nurse Station	2005	85,586	2,852	30	2,853	1	15,703	32
33	Roof Replacement Dietary	2005	14,503	483	30	483		2,620	33
34	TOTAL (lines 1 thru 33)		\$ 5,035,819	\$ 125,475		\$ 126,034	\$ 559	\$ 2,788,741	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,035,819	\$ 125,475		\$ 126,034	\$ 559	\$ 2,788,741	1
2	Nurse Station Bumper Guards	2005	491	57	5	60	3	491	2
3	Chimney roofing work	2005	2,180	109	20	109		581	3
4	Install sink	2005	1,345	90	15	90		473	4
5	Transfer switch	2005	2,549	364	7	364		2,014	5
6	Sprinkler system	2005	934	31	30	31		171	6
7	Air conditioning unit	2005	3,300	220	15	220		1,169	7
8	Sprinkler head	2005	1,458	49	30	49		247	8
9	Gas shut-off fire system	2005	2,600	87	30	87		464	9
10	Fire alarm	2005	11,087	739	15	739		3,847	10
11	Boiler pump	2005	3,986	399	10	399		2,012	11
12	Door	2006	1,379	138	10	138		575	12
13	Plumbing	2006	1,023	102	10	102		442	13
14	Carpeting	2006	2,618	262	10	262		1,288	14
15	Draperies	2006	174	25	7	25		123	15
16	Dining room wallpaper, lighting	2007	3,531	276	8	441	165	1,720	16
17	Public address system	2007	461	92	5	92		333	17
18	Asphalt road repairs	2007	18,979	1,265	15	1,265		4,637	18
19	Room 701 flooring, lighting	2007	1,371	175	8	171	(4)	628	19
20	Sidewalk repairs	2007	3,054	328	10	305	(23)	1,083	20
21	Room 707 flooring, cabinetry	2007	1,208	148	8	151	3	539	21
22	Carpeting room 709	2007	591	74	8	74		248	22
23	Room 603 wallpaper, window coverings, lighting	2007	815	155	8	102	(53)	323	23
24	Room 612, lighting, flooring	2007	673	84	8	84		266	24
25	Room 604 window coverings	2007	55		1			55	25
26	Wallcoverings hall and 4 rooms	2007	1,400	175	8	175		547	26
27	Gate concrete pad	2007	725	222	3	221	(1)	725	27
28	Plumbing wing 1	2007	2,500	312	8	313	1	960	28
29	Fire alarm system upgrade	2007	4,150	100	8	519	419	1,581	29
30	Driveway curbing	2008	3,300	220	15	220		580	30
31	Plumbing, lighting, wallpaper	2008	7,686	929	8	961	32	2,846	31
32	Carpeting and door replacement	2008	1,200	171	8	150	(21)	444	32
33	Fireproofing and sprinklers	2008	33,288	3,376	15	2,219	(1,157)	6,347	33
34	TOTAL (lines 1 thru 33)		\$ 5,155,930	\$ 136,249		\$ 136,172	\$ (77)	\$ 2,826,500	34

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

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 12C, Carried Forward		\$ 5,155,930	\$ 136,249		\$ 136,172	\$ (77)	\$ 2,826,500	1
2	Drainage work	2008	3,460	231	15	231		636	2
3	Eyewash station in kitchen	2008	1,250	156	8	156		420	3
4	Baseboards, wallpaper, carpeting	2008	1,825	186	10	183	(3)	503	4
5	Air conditioning repairs	2008	6,800	850	8	850		2,103	5
6	Elevator repairs	2008	1,206	402	3	402		1,004	6
7	Emergency exit lighting	2008	1,394	174	8	174		407	7
8	Bath tub fixture	2008	729	49	15	49		101	8
9	Wing 1 & Hall 1 draperies, wallpaper, lighting	2008	7,328	1,230	8	916	(314)	2,708	9
10	Draperies, wallpaper, & baseboards	2008	7,251	776	8	906	130	2,684	10
11	Contractor labor & materials for dining room	2008	12,087	1,511	8	1,511		4,475	11
12	Dining room tear-down, tiling, painting, trim	2008	5,716	714	8	715	1	2,117	12
13	Gazebo shingles & vinyl	2009	372	61	7	53	(8)	75	13
14	Chapel fans, shades, ceiling tile & fixtures	2009	9,289	870	5	1,858	988	2,759	14
15	Flooring for rooms 705, 605, 609	2009	1,915	192	10	192		215	15
16	Sod, mulch, road repairs	2010	2,170	32	15	6	(26)	6	16
17	Carpet, Vinyl, Blinds front office & restroom	2010	3,856	504	10	336	(168)	336	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)		\$ 5,222,578	\$ 144,187		\$ 144,710	\$ 523	\$ 2,847,049	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,222,578	\$ 144,187		\$ 144,710	\$ 523	\$ 2,847,049	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)		\$ 5,222,578	\$ 144,187		\$ 144,710	\$ 523	\$ 2,847,049	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010

Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,222,578	\$ 144,187		\$ 144,710	\$ 523	\$ 2,847,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,222,578	\$ 144,187		\$ 144,710	\$ 523	\$ 2,847,049	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,222,578	\$ 144,187		\$ 144,710	\$ 523	\$ 2,847,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 5,222,578	\$ 144,187		\$ 144,710	\$ 523	\$ 2,847,049	34

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	\$ 132,316	\$ 26,819	\$ 26,819	\$	various	\$ 286,108	71
72	Current Year Purchases	5,277	867	867		various	867	72
73	Fully Depreciated Assets	262,739				various	262,739	73
74								74
75	TOTALS	\$ 400,332	\$ 27,686	\$ 27,686	\$		\$ 549,714	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)	\$ 5,634,350	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 171,873	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 172,396	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 523	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,405,817	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 1/1/1980	\$ 21,141	\$ 480	\$ 14,893	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 21,141	\$ 480	\$ 14,893	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 1,550	92
93			93
94			94
95		\$ 1,550	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 1,590

Description: Copier

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2011 \$ _____
13. _____/2012 \$ _____
14. _____/2013 \$ _____

* 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: 01/01/2010 Ending: 12/31/2010

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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$	394	\$ 25,185				394	\$ 25,185	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		540	34,555				540	34,555	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs		380	24,325				380	24,325	4
5	Physician Care	39.3	visits									5
6	Dental Care	39.3	visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39.2	# of prescripts					42,823			42,823	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Exceptional Care</u>	39.2										12
13	Other (specify): <u>Medical Supplies</u>	39.2										13
14	TOTAL			\$	1,314	\$ 84,065		\$ 42,823		1,314	\$ 126,888	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

0042424

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 220,532	\$	1
2	Cash-Patient Deposits	12,607		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (56,000))	496,491		3
4	Supply Inventory (priced at FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	39,284		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	1,109,321		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,822,235	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	146,001		12
13	Land	2,386		13
14	Buildings, at Historical Cost	4,503,595		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	782,585		16
17	Accumulated Depreciation (book methods)	(2,878,316)		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>	1,550		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,557,801	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,380,036	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 68,928	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,607		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,173		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,435		32
33	Accrued Interest Payable	805		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Accrued Expenses</u>	152,657		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 406,605	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,331,623		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)	\$ 2,331,623	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,738,228	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,641,808	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,380,036	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,337,521	1
2	Restatements (describe):		2
3			3
4	<u>Prior period adjustments</u>		4
5	<u>Rounding</u>	3	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,337,524	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	304,284	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)	\$ 304,284	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)	\$ 1,641,808	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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

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

1

	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,365,617	1
2	Discounts and Allowances for all Levels	(1,555,174)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,810,443	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	824,733	6
7	Oxygen	22,552	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 847,285	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	635	12
13	Barber and Beauty Care	3,242	13
14	Non-Patient Meals	87,501	14
15	Telephone, Television and Radio	7,087	15
16	Rental of Facility Space		16
17	Sale of Drugs	45,316	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,593	19
20	Radiology and X-Ray	4,064	20
21	Other Medical Services	85,282	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 250,720	23
D. Non-Operating Revenue			
24	Contributions	97,538	24
25	Interest and Other Investment Income****	969	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 98,507	26
E. Other Revenue (specify):*****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Admission Fee	(250)	28
28a	Miscellaneous	15,574	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,324	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,022,279	30

2

	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,099,777	31
32	Health Care	2,392,235	32
33	General Administration	1,830,501	33
B. Capital Expense			
34	Ownership	303,931	34
C. Ancillary Expense			
35	Special Cost Centers	42,823	35
36	Provider Participation Fee	48,728	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,717,995	40
41	Income before Income Taxes (line 30 minus line 40)**	304,284	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 304,284	43

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

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

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

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

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,984	2,120	\$ 72,156	\$ 34.04	1
2	Assistant Director of Nursing	440	440	11,638	26.45	2
3	Registered Nurses	11,408	12,402	197,257	15.91	3
4	Licensed Practical Nurses	17,539	18,669	366,118	19.61	4
5	CNAs & Orderlies	71,261	75,511	950,434	12.59	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	3,755	4,052	53,843	13.29	8
9	Activity Director	2,112	2,352	34,501	14.67	9
10	Activity Assistants	2,682	2,913	30,300	10.40	10
11	Social Service Workers	3,427	3,575	77,216	21.60	11
12	Dietician	1,984	2,120	30,318	14.30	12
13	Food Service Supervisor	2,056	2,120	31,926	15.06	13
14	Head Cook	-	-	-		14
15	Cook Helpers/Assistants	20,784	22,433	228,509	10.19	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	3,383	3,695	57,274	15.50	17
18	Housekeepers	13,041	13,689	147,627	10.78	18
19	Laundry	1,952	2,127	20,359	9.57	19
20	Administrator	1,800	1,920	76,602	39.90	20
21	Assistant Administrator	-	-	-		21
22	Other Administrative	-	-	-		22
23	Office Manager	-	-	-		23
24	Clerical	1,330	1,683	30,263	17.98	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>	-	-	159,914		33
34	TOTAL (lines 1 - 33)	160,938	171,821	\$ 2,576,255 *	\$ 14.99	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	24	1,440	10.3	37
38	Nurse Consultant	-	-	10.3	38
39	Pharmacist Consultant	14	1,045	10.3	39
40	Physical Therapy Consultant	-	-	10a.3	40
41	Occupational Therapy Consultant	-	-	10a.3	41
42	Respiratory Therapy Consultant	-	-		42
43	Speech Therapy Consultant	-	-	10a.3	43
44	Activity Consultant	-	-	11.3	44
45	Social Service Consultant	18	1,068	12.3	45
46	Other(specify)	-	-		46
47					47
48					48
49	TOTAL (lines 35 - 48)	107	\$ 11,253		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	672	\$ 22,387	10.3	50
51	Licensed Practical Nurses	1,072	37,578	10.3	51
52	Certified Nurse Assistants/Aides	7	117	10.3/10a.3	52
53	TOTAL (lines 50 - 52)	1,751	\$ 60,082		53

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	
Cindy Lewton	Administrator		\$ 76,602	Workers' Compensation Insurance	\$ 183,228	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	51,752	Advertising: Employee Recruitment	6,830	
				FICA Taxes	192,003	Health Care Worker Background Check	796	
				Employee Health Insurance	153,601	(Indicate # of checks performed <u>49</u>)		
				Employee Meals		Patient Background Checks <u>54</u>	540	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of IL	4,854	
				Employee Pension Plan	21,187	Mennonite Health Services	8,190	
				Employee Life/Disability	5,588	Dues & Licenses	3,429	
				Employee Uniforms		Subscriptions & Newspapers	547	
				Employee Physicals, Hep. B.	12,109	Rounding		
				Employee Appreciation	12,008	Less: Public Relations Expense ()		
				Maple Lawn Homes, Inc. Alloc.	71,729	Non-allowable advertising	(54)	
				Rounding	(1)	Yellow page advertising	(4,899)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,602	TOTAL (agree to Schedule V, line 22, col.8)	\$ 703,204	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,223	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	237
							Seminar Expense	8,286
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 8,523
C. Professional Services								
Vendor/Payee	Type		Amount					
McGladrey & Pullen			\$ 52,624					
Robert Rein			6,072					
Reclassifications			360					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 59,056					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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												
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:

01/01/2010

Ending:

12/31/2010

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? 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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 42,463 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 no NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO no 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. \$ 46,715
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. \$ 87,501
- (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? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen
- (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.