FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0042424

Facility Name: Maple Lawn Health Center

Address: 700 N. Main Street (Number) Eureka (City) 61530 (Zip Code)

County: Woodford

Telephone Number: (309) 467-2337 Fax # (309) 467-9097

HFS ID Number:

Date of Initial License for Current Owners: 1922

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeff Corron Telephone Number: (309) 467-2337
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Jeff Corron
(Title) Chief Financial Officer

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	-	-	2,139	2,139	8
9	SNF/PED					9
10	ICF	14,539	12,363		26,902	10
11	ICF/DD	-	-			11
12	SC	-	4,091		4,091	12
13	DD 16 OR LESS	-	-			13
14	TOTALS	14,539	16,454	2,139	33,132	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.769259345

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 [X] NO [ ]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 89 and days of care provided 2,139

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	325,686	24,345	-	350,031	-	350,031	-	350,031			1
2	Food Purchase		330,559		330,559	-	330,559	(102,450)	228,109			2
3	Housekeeping	183,141	24,788	-	207,929	-	207,929	-	207,929			3
4	Laundry	18,409	8,530	-	26,939	-	26,939	(575)	26,364			4
5	Heat and Other Utilities			114,915	114,915	-	114,915	7,438	122,353			5
6	Maintenance	63,740	9,648	88,605	161,993	-	161,993	4,441	166,434			6
7	Other (specify):*	-	-	-	-	-	-	-	-			7
8	TOTAL General Services	590,976	397,870	203,520	1,192,366	-	1,192,366	(91,146)	1,101,220			8
	B. Health Care and Programs											
9	Medical Director			9,100	9,100	-	9,100		9,100			9
10	Nursing and Medical Records	1,646,162	90,513	21,725	1,758,400	-	1,758,400		1,758,400			10
10a	Therapy	56,609	1,332	258,605	316,546	-	316,546		316,546			10a
11	Activities	73,375	2,444	2,356	78,175	(480)	77,695		77,695			11
12	Social Services	65,121	3,819	884	69,824	480	70,304		70,304			12
13	CNA Training				-	-	-		-			13
14	Program Transportation				-	-	-		-			14
15	Other (specify):*				-	-	-		-			15
16	TOTAL Health Care and Programs	1,841,267	98,108	292,670	2,232,045	-	2,232,045	-	2,232,045			16
	C. General Administration											
17	Administrative	82,570	-	471,912	554,482	-	554,482	(471,912)	82,570			17
18	Directors Fees			-	-	-	-	-	-			18
19	Professional Services			38,648	38,648	-	38,648	5,148	43,796			19
20	Dues, Fees, Subscriptions & Promotions			40,152	40,152	(1,608)	38,544	(3,998)	34,546			20
21	Clerical & General Office Expenses	106,965	(4,326)	302,933	405,572	1,692	407,264	271,371	678,635			21
22	Employee Benefits & Payroll Taxes			726,189	726,189	-	726,189	54,011	780,200			22
23	Inservice Training & Education			-	-	-	-	-	-			23
24	Travel and Seminar			14,367	14,367	(84)	14,283	-	14,283			24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-			25
26	Insurance-Prop.Liab.Malpractice			85,366	85,366	-	85,366	941	86,307			26
27	Other (specify):*		-	-	-	-	-	-	-			27
28	TOTAL General Administration	189,535	(4,326)	1,679,567	1,864,776	-	1,864,776	(144,439)	1,720,337			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,621,778	491,652	2,175,757	5,289,187	-	5,289,187	(235,585)	5,053,602			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: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger								FOR BHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			173,768	173,768	-	173,768	46,372	220,140			30
31	Amortization of Pre-Op. & Org.			-	-	-	-	-	-			31
32	Interest			122,690	122,690	-	122,690	6,748	129,438			32
33	Real Estate Taxes			3,354	3,354	-	3,354	-	3,354			33
34	Rent-Facility & Grounds			-	-	-	-	-	-			34
35	Rent-Equipment & Vehicles			-	-	-	-	-	-			35
36	Other (specify):*			-	-	-	-	-	-			36
37	TOTAL Ownership			299,812	299,812	-	299,812	53,120	352,932			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-	-	-	-	-			38
39	Ancillary Service Centers	-	59,922	4,697	64,619	-	64,619	-	64,619			39
40	Barber and Beauty Shops	-	-	-	-	-	-	-	-			40
41	Coffee and Gift Shops	-	-	-	-	-	-	-	-			41
42	Provider Participation Fee	-	-	48,728	48,728	-	48,728	-	48,728			42
43	Other (specify):*	-	-	-	-	-	-	-	-			43
44	TOTAL Special Cost Centers	-	59,922	53,425	113,347	-	113,347	-	113,347			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,621,778	551,574	2,528,994	5,702,346	-	5,702,346	(182,465)	5,519,881			45

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(101,745)	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	(5,565)	30.3		9
10	Interest and Other Investment Income	(574)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,663)	20.3		28
29	Other-Attach Schedule	(32,832)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (144,379)		$	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 Amount	2 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)	(38,086)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (38,086)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (182,465)		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 Yes	2 No	3 Amount	4 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: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Maple Lawn 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. [x] 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%	$ 7,438	$ 7,438	1
2	V	6	Maintenance	-	Maple Lawn Homes, Inc.	100%	4,441	4,441	2
3	V	12	Social Services	-	Maple Lawn Homes, Inc.	100%	-	-	3
4	V	19	Professional Service	-	Maple Lawn Homes, Inc.	100%	5,148	5,148	4
5	V	21	Administrative and General	-	Maple Lawn Homes, Inc.	100%	295,676	295,676	5
6	V	17	Administrative and General	471,912	Maple Lawn Homes, Inc.	100%	-	(471,912)	6
7	V	22	Employee Benefits	-	Maple Lawn Homes, Inc.	100%	54,011	54,011	7
8	V	26	Insurance	-	Maple Lawn Homes, Inc.	100%	941	941	8
9	V	30	Depreciation	-	Maple Lawn Homes, Inc.	100%	52,417	52,417	9
10	V	32	Interest	-	Maple Lawn Homes, Inc.	100%	7,322	7,322	10
11	V	33	Real Estate Tax	-	Maple Lawn Homes, Inc.	100%	6,432	6,432	11
12	V	43	Development	-	Maple Lawn Homes, Inc.	100%	-	-	12
13	V			-			-	-	13
14	Total			$ 471,912			$ 433,826	$ * (38,086)	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: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 01/01/2011 Ending: 12/31/2011

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 [x] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost	7,601,501	3	$ 9,915	$	5,702,346	$ 7,438	1
2	6	Maintenance	Accumulated Cost	7,601,501	3	5,920		5,702,346	4,441	2
3	19	Professional Service	Accumulated Cost	7,601,501	3	6,863		5,702,346	5,148	3
4	21	Supplies	Accumulated Cost	7,601,501	3	19,040		5,702,346	14,283	4
5	21	Administrative and General	Accumulated Cost	7,601,501	3	375,110	338,911	5,702,346	281,393	5
6	22	Employee Benefits	Accumulated Cost	7,601,501	3	71,999		5,702,346	54,011	6
7	26	Insurance - Prop. Liab.	Accumulated Cost	7,601,501	3	1,255		5,702,346	941	7
8	30	Depreciation	Accumulated Cost	7,601,501	3	69,875		5,702,346	52,417	8
9	32	Interest	Accumulated Cost	7,601,501	3	9,761		5,702,346	7,322	9
10	33	Real Estate Tax	Accumulated Cost	7,601,501	3	8,574		5,702,346	6,432	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					$ 578,312	$ 338,911		$ 433,826	25

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	FHA Mortgage # 2		X	Building	$6,300.00	1989	900,000	130,117	2014	0.0650	9,927	2
3	FHA Mortgage # 5		x	Building	$1,779.00	2004	400,000	311,024	2034	0.04125	12,006	3
4	City of Eureka Bonds		X	Building	$3,465.00	1989	455,000	66,900	2012	0.0712	1,370	4
5	FHA Mortgage # 4		X	Building	$5,500.00	2004	305,000	940,167	2034	0.0438	40,545	5
	Working Capital											
6	Heartland		X	Line of credit	varies	2004	112,000	1,465,050	2008	0.0600	58,842	6
7												7
8												8
9	TOTAL Facility Related				$17,044.00		$ 2,172,000	$ 2,913,258			$ 122,690	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	$ 2,913,258			$ 122,690	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: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.	$ 2,435	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.)		$ 2,757	2
3. Under or (over) accrual (line 2 minus line 1).		$ 322	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 3,032	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.		$ 3,354	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	2,734	8
	2007	2,734	9
	2008	2,665	10
	2009	2,722	11
	2010	2,757	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

* 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.

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: 2010 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 2010 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2010.

Please complete the Real Estate Tax Statement below and include it in the 2011 cost report along with a copy of your 2010 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.

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-201-026	700 N. Main Street, Beauty Shop	$ 2,757	$ 2,757
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 2,757	$ 2,757

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 01/01/2011 Ending: 12/31/2011

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? [x] (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? [x] (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 [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Health Center	85,000	1965	$ 1,386	1
2	Health Center	39,000	1969	1,000	2
3	TOTALS	124000		$ 2,386	3

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1965	1965	$ 472,000	$ 7,867	60	$ 7,867	$	$ 369,081	4
5			1974	1974	20,378	408	50	408		15,239	5
6			1980	1980	750,017	16,667	45	16,667		531,618	6
7			1982	1982	7,703		20			7,703	7
8	38		1989	1989	1,459,363	32,431	45	32,430	(1)	729,679	8
	Improvement Type**										
9	Landscaping			1982	1,155		20			1,155	9
10	Trees			1984	3,101		20			3,101	10
11	Landscaping - Front of HC			1992	1,100		10			1,100	11
12	Asphalt Repair			1993	4,058		10			4,058	12
13	Parking Lot Lighting & Asphalt			1995	3,810		10			3,810	13
14	ADU Enclosure			1995	4,305		10			4,305	14
15	Parking Blocks (20)			1996	654		10			654	15
16	Lower Level Renovation			1981	203,080		23			203,080	16
17	Lower Level Renovation			1982	35,963		22			35,963	17
18	Fixture Repairs & Refinish, Trellis			1983	12,213		10			12,213	18
19	Loading Dock			1985	1,642		20			1,642	19
20	Deck & Room Renovation			1992	3,641		10			3,641	20
21	Lobby Renovation & Central supply rm			1993	34,280		10			34,280	21
22	ADU Cabinets & Wallpaper			1994	2,141		10			2,141	22
23	Wallpaper, Carpet rm 702, Admin office			1995	2,822		8			2,822	23
24	Lobby Carpet,Kitchen ramp, rm renovate			1996	20,881		10			20,881	24
25	Walk in Freezer			1975	2,853		10			2,853	25
26	Sprinkler Installation			1976	11,240		20			11,240	26
27	Sprinkler Installation			1977	743		20			743	27
28	Generator			1980	9,500		20			9,500	28
29	Lighting, Flooring, Air Vent			1982	6,400		20			6,400	29
30	Exhaust Fan			1984	2,800		20			2,800	30
31	Entrance Load Control & Lighting			1985	14,608		10			14,608	31
32	Water Softner			1987	699		5			699	32
33	Alarm System			1989	5,473		15			5,473	33
34	Wander Guard,Door Alarms,Disposal,A/C			1990	12,492		8			12,492	34
35	A/C, Mgmt Sys, Curtains			1991	15,468		20			15,468	35
36	Water heater Tanks			1992	12,622		15			12,622	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
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		-	6,642	38
39	Toaster,Fiber Optics,A/C,Signage,Counter,Bath	1995	25,208	159	10		(159)	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,Parkin	1998	69,271		10		-	69,271	44
45	Asphalt,DiningRm,Hall,Door,Bath,ElecEye	1999	24,138		10		-	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		10		-	2,352	47
48	Tempered Water System Redesigned	2000	14,400	720	20	720	-	8,400	48
49	Renovate Social Service Office	2000	3,422	342	10		(342)	3,422	49
50	Wanderguard Monitors	2000	2,591		8		-	2,591	50
51	New Boiler in Cleveland Steamer	2000	4,076		10		-	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			10		-		54
55	Water System Installation	2001	41,500	2,075	20	2,075	-	22,652	55
56	Administrative Office - Carpet	2001			8		-		56
57	Fire Alarms- Halls 4 & 5	2001	6,436		8		-	6,436	57
58	Air Condition Unit Hall 6	2001	3,424		10	145	145	3,424	58
59	Door Alarms - Hall 7	2001	2,757		8		-	2,757	59
60	Elevator Safety Edges	2002	3,245	324	10	325	1	3,114	60
61	Reshingle - Memorial Hall	2002		37	20		(37)		61
62	A/C Condensor - HC Lobby	2002			10		-		62
63	Cable System Upgrade	2002	1,138		5		-	1,138	63
64	Sandblasted Redwood Signs	2002			7		-		64
65	Room 601 Construction	2003	34,315	1,716	20	1,716	-	14,872	65
66	Room 306 Bathroom Conversion	2003	21,425	2,142	10	2,143	1	18,572	66
67	PT Room Divider Curtain	2003	2,589	259	10	259	-	2,245	67
68	Crosslink II Traverline Carpet	2003			8		-		68
69	Insinkerator Disposer for Kitchen	2003	1,048		5		-	1,048	69
70	TOTAL (lines 4 thru 69)		$ 3,585,068	$ 65,147		$ 64,755	$ (392)	$ 2,481,308	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12A, Carried Forward		$ 3,585,068	$ 65,147		$ 64,755	$ (392)	$ 2,481,308	1
2	New Exit Doors & Keypads	2003	9,618		7			9,618	2
3	New Parking Lot	2003	9,378	782	12	782	-	6,712	3
4	Wallpaper -Rm 302/Hall#1/Dining Rm	2003			7		-		4
5	Wallpaper Stock for Room Renovations	2003			7		-		5
6	Asbestos removal - Dining Rm Floor	2003	10,520		7		-	10,520	6
7	Vinyl Flooring in Dining Rm	2003	12,700		7		-	12,700	7
8	Wallpaper Hall 2	2004			7		-		8
9	Expansion Dining Room	2004	2,612	174	15	174	-	1,369	9
10	Flooring for Elevator	2004	1,479	185	8	185	-	1,375	10
11	Walk-in Cooler	2004	8,043	804	10	804	-	6,265	11
12	Door Lock	2004	3,313		7	103	103	3,313	12
13	Telephone System	2004	16,115	1,612	10	1,612	-	12,401	13
14	Draperies	2004			7		-		14
15	Draperies	2004			7		-		15
16	Sealcoat Parking Lot	2004	2,479		3		-	2,479	16
17	Landscaping	2004	2,778	278	10	278	-	2,077	17
18	Renovation on resident rooms, hallways	2005	614,348	22,942	30	20,478	(2,464)	143,290	18
19	Roof replacement	2005	414,304	13,810	30	13,810	-	96,632	19
20	Resident room doors and refinishing	2005	6,164	205	30	205	-	1,339	20
21	Carpet and Tile Flooring	2005	39,119	2,608	15	2,608	-	16,963	21
22	Wallpaper for lobby	2005	3,921	392	10	392	-	2,550	22
23	Sprinkler system	2005	71,880	2,396	30	2,396	-	16,765	23
24	Lighting resident rooms and lobby.	2005	4,754	159	30	158	(1)	1,032	24
25	Time clock system	2005		3,429	10		(3,429)		25
26	Privacy track, window rods, draperies	2005	5,678	717	7	811	94	5,675	26
27	Carpeting room 608	2005		95	8		(95)		27
28	Wiring Upgrade	2005	1,498		5		-	1,498	28
29	A/C condenser replacement	2005	4,775	318	15	318	-	2,095	29
30	Boiler replacement	2005	4,495	450	10	450	-	3,012	30
31	Asphalt Repairs	2005			5		-		31
32	Renovate Multi-Rm/Nurse Station	2005	85,586	2,852	30	2,853	1	18,556	32
33	Roof Replacement Dietary	2005	14,503	483	30	483		3,103	33
34	TOTAL (lines 1 thru 33)		$ 4,935,128	$ 119,838		$ 113,655	$ (6,183)	$ 2,862,647	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		$ 4,935,128	$ 119,838		$ 113,655	$ (6,183)	$ 2,862,647	1
2	Nurse Station Bumper Guards	2005			5				2
3	Chimney roofing work	2005	2,180	109	20	109		690	3
4	Install sink	2005	1,345	90	15	90		563	4
5	Transfer switch	2005	2,549	364	7	364		2,378	5
6	Sprinkler system	2005		31	30		(31)		6
7	Air conditioning unit	2005	3,300	220	15	220		1,389	7
8	Sprinkler head	2005	1,458	49	30	49		296	8
9	Gas shut-off fire system	2005	2,600	87	30	87		551	9
10	Fire alarm	2005	11,087	739	15	739		4,586	10
11	Boiler pump	2005	3,986	399	10	399		2,411	11
12	Door	2006	1,379	138	10	138		713	12
13	Plumbing	2006	1,023	102	10	102		544	13
14	Carpeting	2006	2,618	262	10	262		1,550	14
15	Draperies	2006	174	25	7	25		148	15
16	Dining room wallpaper, lighting	2007	3,531	276	8	441	165	2,161	16
17	Public address system	2007	461	92	5	92		425	17
18	Asphalt road repairs	2007	18,979	1,265	15	1,265		5,902	18
19	Room 701 flooring, lighting	2007	1,371	145	8	171	26	799	19
20	Sidewalk repairs	2007	3,054	328	10	305	(23)	1,388	20
21	Room 707 flooring, cabinetry	2007	1,208	148	8	151	3	690	21
22	Carpeting room 709	2007	591	74	8	74		322	22
23	Room 603 wallpaper, window coverings, lighting	2007	815	4	8	102	98	425	23
24	Room 612, lighting, flooring	2007	673	84	8	84		350	24
25	Room 604 window coverings	2007	55		1			55	25
26	Wallcoverings hall and 4 rooms	2007	1,400	175	8	175		722	26
27	Gate concrete pad	2007	725		3			725	27
28	Plumbing wing 1	2007	2,500	312	8	313	1	1,273	28
29	Fire alarm system upgrade	2007	4,150	100	8	519	419	2,100	29
30	Driveway curbing	2008	3,300	220	15	220		800	30
31	Plumbing, lighting, wallpaper	2008	7,686	864	8	961	97	3,807	31
32	Carpeting and door replacement	2008	1,200	137	8	150	13	594	32
33	Fireproofing and sprinklers	2008	33,288	3,376	15	2,219	(1,157)	8,566	33
34	TOTAL (lines 1 thru 33)		$ 5,053,814	$ 130,053		$ 123,481	$ (6,572)	$ 2,909,570	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12C, Carried Forward		$ 5,053,814	$ 130,053		$ 123,481	$ (6,572)	$ 2,909,570	1
2	Drainage work	2008	3,460	231	15	231		867	2
3	Eyewash station in kitchen	2008	1,250	156	8	156		576	3
4	Baseboards, wallpaper, carpeting	2008	1,825	186	10	183	(3)	686	4
5	Air conditioning repairs	2008	6,800	850	8	850		2,953	5
6	Elevator repairs	2008	1,206		3	202	202	1,206	6
7	Emergency exit lighting	2008	1,394	174	8	174		581	7
8	Bath tub fixture	2008	729	49	15	49		150	8
9	Wing 1 & Hall 1 draperies, wallpaper, lighting	2008	7,328	1,040	8	916	(124)	3,624	9
10	Draperies, wallpaper, & baseboards	2008	7,251	776	8	906	130	3,590	10
11	Contractor labor & materials for dining room	2008	12,087	1,511	8	1,511		5,986	11
12	Dining room tear-down, tiling, painting, trim	2008	5,716	714	8	715	1	2,832	12
13	Gazebo shingles & vinyl	2009	372	61	7	53	(8)	128	13
14	Chapel fans,shades,ceiling tile & fixtures	2009	9,289	870	5	1,858	988	4,617	14
15	Flooring for rooms 705, 605, 609	2009	1,915	192	10	192		407	15
16	Sod, mulch, road repairs	2010	2,170	163	15	145	(18)	151	16
17	Carpet, Vinyl, Blinds front office & restroom	2010	3,856	612	10	386	(226)	722	17
18	2 boiler pumps and douglas fir	2011	3,356	19	15	12	(7)	12	18
19	Circuit breaker, wall heater,wanderguard monitor, A/C	2011	4,138	171	15	241	70	241	19
20	Serenity walls, floor, electrical	2011	80,450	3,129	15	3,130	1	3,130	20
21	Physician office floor, wall, electrical	2011	7,767	43	15	44	1	44	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)		$ 5,216,173	$ 141,000		$ 135,435	$ (5,565)	$ 2,942,073	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 149,739	$ 31,353	$ 31,353	$	various	$ 318,328	71
72	Current Year Purchases	7,550	935	935		various	935	72
73	Fully Depreciated Assets	262,739				various	262,739	73
74								74
75	TOTALS	$ 420,028	$ 32,288	$ 32,288	$		$ 582,002	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2001, Ford van	2005	$ 9,054	$	$	$	5	$ 9,054	76
77										77
78										78
79										79
80	TOTALS			$ 9,054	$	$	$		$ 9,054	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,647,641	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 173,288	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,723	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,565)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,533,129	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	281 Walkway 1980	$ 21,141	$ 480	$ 15,373	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 21,141	$ 480	$ 15,373	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	$ 41,438	92
93			93
94			94
95		$ 41,438	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 [x] 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 [x] NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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: 01/01/2011 Ending: 12/31/2011

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? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	412	$	35,387	$	412	$ 35,387	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		415		37,388		415	37,388	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a.3	hrs		465		39,979		465	39,979	4
5	Physician Care	39.3	visits								5
6	Dental Care	39.3	visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39.2	# of prescrpts					52,076		52,076	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): Exceptional Care	39.2									12
13	Other (specify): Medical Supplies	39.2						3,225		3,225	13
14	TOTAL			$	1,292	$	112,754	$ 55,301	1,292	$ 168,055	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: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 247,785	$	1
2	Cash-Patient Deposits	8,332		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (80,530))	830,611		3
4	Supply Inventory (priced at FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,700		6
7	Other Prepaid Expenses	9,534		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany	1,960,261		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 3,087,223	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	157,996		12
13	Land	2,386		13
14	Buildings, at Historical Cost	4,592,807		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	837,873		16
17	Accumulated Depreciation (book methods)	(3,093,272)		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): Construction in Process	41,438		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 2,539,228	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 5,626,451	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 197,806	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,332		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	145,112		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,032		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Expenses	123,848		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 478,130	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,913,258		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)	$ 2,913,258	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 3,391,388	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 2,235,063	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 5,626,451	$	48

*(See instructions.)

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 1,641,808	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	11,995	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 1,653,803	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	581,260	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)	$ 581,260	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)	$ 2,235,063	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,904,332	1
2	Discounts and Allowances for all Levels	(1,701,206)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 5,203,126	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	555,971	6
7	Oxygen	17,350	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 573,321	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	705	12
13	Barber and Beauty Care	4,125	13
14	Non-Patient Meals	101,745	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,066	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,390	19
20	Radiology and X-Ray	4,291	20
21	Other Medical Services	122,660	21
22	Laundry	575	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 268,557	23
	D. Non-Operating Revenue		
24	Contributions	207,916	24
25	Interest and Other Investment Income***	574	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 208,490	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Admission Fee		28
28a	Miscellaneous	30,112	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 30,112	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 6,283,606	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,192,366	31
32	Health Care	2,232,045	32
33	General Administration	1,864,776	33
	B. Capital Expense		
34	Ownership	299,812	34
	C. Ancillary Expense		
35	Special Cost Centers	64,619	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)*	$ 5,702,346	40
41	Income before Income Taxes (line 30 minus line 40)**	581,260	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 581,260	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: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,568	1,675	$ 58,843	$ 35.13	1
2	Assistant Director of Nursing	1,512	1,512	41,516	27.46	2
3	Registered Nurses	4,452	4,840	119,138	24.62	3
4	Licensed Practical Nurses	19,695	20,964	468,599	22.35	4
5	CNAs & Orderlies	65,951	69,884	940,338	13.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,437	3,709	56,609	15.26	8
9	Activity Director	1,952	2,174	31,255	14.38	9
10	Activity Assistants	3,119	3,697	42,120	11.39	10
11	Social Service Workers	3,801	3,965	65,121	16.42	11
12	Dietician	1,896	2,026	49,128	24.25	12
13	Food Service Supervisor	1,904	1,963	31,896	16.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,611	22,246	244,662	11.00	15
16	Dishwashers					16
17	Maintenance Workers	2,657	2,591	63,740	24.60	17
18	Housekeepers	13,400	14,066	183,141	13.02	18
19	Laundry	1,575	1,716	18,409	10.73	19
20	Administrator	1,664	1,775	82,570	46.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,131	6,493	106,965	16.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,621	1,718	17,728	10.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,946	167,014	$ 2,621,778 *	$ 15.70	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$	1.3	35
36	Medical Director	61	9,100	9.3	36
37	Medical Records Consultant	19	1,650	10.3	37
38	Nurse Consultant	4	360	10.3	38
39	Pharmacist Consultant	12	1,800	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	8	496	11.3	44
45	Social Service Consultant	22	1,364	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	126	$ 14,770		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides			10.3/10a.3	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
See Schedule			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,570

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 38,648

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 252,157
Unemployment Compensation Insurance	64,068
FICA Taxes	192,541
Employee Health Insurance	175,226
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	19,263
Employee Life/Disability	6,024
Employee Uniforms	
Employee Physicals, Hep. B.	2,928
Employee Appreciation	13,984
Maple Lawn Homes, Inc. Alloc.	54,011
Rounding	(2)
TOTAL (agree to Schedule V, line 22, col.8)	$ 780,200

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,098
Health Care Worker Background Check	560
(Indicate # of checks performed 20)	
Patient Background Checks 74	740
Illinois Health Care Association	4,922
Mennonite Health Services	5,325
Dues & Licenses	12,606
Subscriptions & Newspapers	293
Rounding	
Less: Public Relations Expense	( )
Non-allowable advertising	(335)
Yellow page advertising	(3,663)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,546

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,134
Seminar Expense	13,149
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,283

**See instructions.

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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	Amount of Expense Amortized Per Year								
					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: 01/01/2011 Ending: 12/31/2011

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. Illinois Health Care Association 4,922

(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? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 48,880 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. $ 101,745

(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: Heinold-Banwart Ltd.

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.