FOR BHF USE

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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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0042424

Facility Name: Maple Lawn Health Center

Address: 700 North Main St (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
X	Charitable Corp.
	Trust

IRS Exemption Code 501 (c) 3

	PROPRIETARY
	Individual
	Partnership
	Corporation
	"Sub-S" Corp.
	Limited Liability Co.
	Trust
	Other

	GOVERNMENTAL
	State
	County
	Other

In the event there are further questions about this report, please contact:

Name: Jeremy LaKosh 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 1/1/16 to 7/31/16 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) Jeremy LaKosh

(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	18,957	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	4,899	5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	23,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		Patient Days by Level of Care and Primary Source of Payment				
8	SNF			608	608	8
9	SNF/PED					9
10	ICF	5,944	5,474		11,418	10
11	ICF/DD					11
12	SC		3,282		3,282	12
13	DD 16 OR LESS					13
14	TOTALS	5,944	8,756	608	15,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.17%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [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 493

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 7/31/16 Fiscal Year: 7/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number: Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	142,583	11,872		154,455		154,455		154,455			1
2	Food Purchase		136,039		136,039		136,039	(38,073)	97,966			2
3	Housekeeping	76,242	10,745		86,987		86,987		86,987			3
4	Laundry	16,736			16,736		16,736		16,736			4
5	Heat and Other Utilities			81,517	81,517		81,517		81,517			5
6	Maintenance	20,529	4,693	116,004	141,226		141,226		141,226			6
7	Other (specify):* Waste Removal			8,610	8,610		8,610		8,610			7
8	TOTAL General Services	256,090	163,349	206,131	625,570		625,570	(38,073)	587,497			8
	B. Health Care and Programs											
9	Medical Director			7,000	7,000		7,000		7,000			9
10	Nursing and Medical Records	775,250	50,719	5,718	831,687		831,687		831,687			10
10a	Therapy	32,810	61	73,103	105,974		105,974		105,974			10a
11	Activities	79,469	2,119	976	82,564		82,564		82,564			11
12	Social Services	9,815	401	942	11,158		11,158		11,158			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	897,344	53,300	87,739	1,038,383		1,038,383		1,038,383			16
	C. General Administration											
17	Administrative	75,994			75,994		75,994		75,994			17
18	Directors Fees											18
19	Professional Services			145,986	145,986		145,986	(61,047)	84,939			19
20	Dues, Fees, Subscriptions & Promotions			10,539	10,539		10,539		10,539			20
21	Clerical & General Office Expenses	162,625	16,691	35,132	214,448		214,448	(4,953)	209,495			21
22	Employee Benefits & Payroll Taxes			257,214	257,214		257,214		257,214			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,263	2,263		2,263		2,263			24
25	Other Admin. Staff Transportation		1,259	2,321	3,580		3,580		3,580			25
26	Insurance-Prop.Liab.Malpractice			20,053	20,053		20,053		20,053			26
27	Other (specify):*											27
28	TOTAL General Administration	238,619	17,950	473,508	730,077		730,077	(66,000)	664,077			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,392,053	234,599	767,378	2,394,030		2,394,030	(104,073)	2,289,957			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Maple Lawn Health Center #0042424 **Report Period Beginning:** 1/1/16 **Ending:** 7/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			157,755	157,755		157,755	91,438	249,193			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,854	79,854		79,854		79,854			32
33	Real Estate Taxes			21,196	21,196		21,196		21,196			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			258,805	258,805		258,805	91,438	350,243			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,358	4,601	23,959		23,959		23,959			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			92,228	92,228		92,228		92,228			42
43	Other (specify):* Disallowed Costs	18,194	2,021	168,835	189,050		189,050	(189,050)				43
44	TOTAL Special Cost Centers	18,194	21,379	265,664	305,237		305,237	(189,050)	116,187			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,410,247	255,978	1,291,847	2,958,072		2,958,072	(201,685)	2,756,387			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	(38,073)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,592)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	91,438	30		9
10	Interest and Other Investment Income				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	(61,047)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(181,438)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(4,973)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (201,685)		$	30

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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (201,685)		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						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BHF USE ONLY

48		49		50		51		52	

SEE ACCOUNTANTS' PREPARATION REPORT

Maple Lawn Health Center

ID# 0042424

Report Period Beginning: 1/1/16

Ending: 7/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Cottingham Revenue	$ (3,898)	21	1
2	Offset Miscellaneous Revenue	(1,055)	21	2
3	Meals on Wheels License	(20)	43	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,973)		49

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(38,073)	0	0	0	0	0	0	0	0	0	0	(38,073)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(38,073)	0	0	0	0	0	0	0	0	0	0	(38,073)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(61,047)	0	0	0	0	0	0	0	0	0	0	(61,047)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(4,953)	0	0	0	0	0	0	0	0	0	0	(4,953)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(66,000)	0	0	0	0	0	0	0	0	0	0	(66,000)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(104,073)	0	0	0	0	0	0	0	0	0	0	(104,073)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	91,438	0	0	0	0	0	0	0	0	0	0	91,438	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	91,438	0	0	0	0	0	0	0	0	0	0	91,438	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(189,050)	0	0	0	0	0	0	0	0	0	0	(189,050)	43
44	**TOTAL Special Cost Centers**	(189,050)	0	0	0	0	0	0	0	0	0	0	(189,050)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(201,685)	0	0	0	0	0	0	0	0	0	0	(201,685)	45

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	11	Activity Wages	$ 685	Maple Lawn Homes, Inc.	0.00%	$ 685	$	1
2	V	11	Chaplain Wages	29,877	Maple Lawn Homes, Inc.	0.00%	29,877		2
3	V	17	Administrative Wages	70,778	Maple Lawn Homes, Inc.	0.00%	70,778		3
4	V	21	Clerical & Accounting Wages	81,259	Maple Lawn Homes, Inc.	0.00%	81,259		4
5	V	21	Human Resource Wages	31,699	Maple Lawn Homes, Inc.	0.00%	31,699		5
6	V	21	Administrative Asst Wages	19,537	Maple Lawn Homes, Inc.	0.00%	19,537		6
7	V	43	Community Relation Wages	14,857	Maple Lawn Homes, Inc.	0.00%	14,857		7
8	V	43	Development Wages	3,337	Maple Lawn Homes, Inc.	0.00%	3,337		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 252,029			$ 252,029	$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors:							1
2								2
3	Alice Kennell	0						3
4	Dave Neuhauser	0						4
5	Leanne Schertz	0						5
6	Troy Teater	0						6
7	Steve Stewart	0						7
8	Don Litwiller	0						8
9	Lisa Jablonski	0						9
10	Minta Colburn	0						10
11	Eldon Schlupp	0						11
12								12
13								13
14								14
15								15
16								16
17	Note: No Board Members received compensation from the facility.							17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	11	Activity Wages	Estimated Time Spent	100	4	$ 13,700	$ 13,700	5	$ 685	1
2	11	Chaplain Wages	Estimated Time Spent	100	4	33,197	33,197	90	29,877	2
3	17	Administrative Wages	Estimated Time Spent	100	4	78,642	78,642	90	70,778	3
4	21	Clerical & Accounting Wages	Estimated Time Spent	100	4	105,531	105,531	77	81,259	4
5	21	Human Resource Wages	Estimated Time Spent	100	4	35,221	35,221	90	31,699	5
6	21	Administrative Asst Wages	Estimated Time Spent	100	4	24,421	24,421	80	19,537	6
7	43	Community Relation Wages	Estimated Time Spent	100	4	16,508	16,508	90	14,857	7
8	43	Development Wages	Estimated Time Spent	100	4	3,513	3,513	95	3,337	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					$ 310,733	$ 310,733		$ 252,029	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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**		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	Lancaster Pollard Mtg Co		X	Building	$22,812.40	12/1/13	4,480,400	4,325,742	12/1/43	0.0453	$ 47,236	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Heartland Bank & Trust		X	Line of credit	varies	12/11/15	1,200,000	698,252	3/11/16	0.0450	32,618	6
7												7
8												8
9	TOTAL Facility Related				$22,812.40		$ 5,680,400	$ 5,023,994			$ 79,854	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,680,400	$ 5,023,994			$ 79,854	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ none Line # N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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: 1/1/16 Ending: 7/31/16

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description		Amount	
1	1. Real Estate Tax accrual used on 2015 report.		$ 30,019	1
2	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.)	2015	$ 40,193	2
3	3. Under or (over) accrual (line 2 minus line 1).		$ 10,174	3
4	4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 49,236	4
5	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	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.)	Adjustment to HC portion (38,214)	$ (38,214)	6
7	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 21,196	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2011	2,771	8
2012	37,314	9
2013	34,803	10
2014	35,949	11
2015	40,193	12

Accrual based on prior year tax bill for the Administrative building and adjacent land.

2015 RE taxes	40193
Est HC portion	0.52735
RE Tax Exp	21196

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Maple Lawn Health Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0042424

CONTACT PERSON REGARDING THIS REPORT Jeremy LaKosh

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-201-030	700 N. Main Street	$ 36,234.30	$ 19,108.16
2.	13-12-201-029	700 N. Main Street	$ 3,958.94	$ 2,087.75
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,193.24	$ 21,195.91

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	See Attached Sch			$ 2,750	1
2					2
3	TOTALS			$ 2,750	3

SEE ACCOUNTANTS' PREPARATION REPORT

Maple Lawn Health Center

Period Beginning **1/1/16**
Period End **7/31/16**

XI. OWNERSHIP COSTS:

A. Land.

Use	Square Feet	Year Acquired	Cost
Health Center	85,000	1965	1,386
Health Center	39,000	1969	1,000
Administration Bldg Land Allocation			364
TOTALS	**124,000**		**$ 2,750**

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	$	60	$ 7,867	$ 7,867	$ 408,416	4
5			1974	1974	20,378		50	408	408	17,279	5
6			1980	1980	750,017		45	16,667	16,667	614,953	6
7			1982	1982	7,703		20			7,703	7
8	38		1989	1989	1,459,363		45	32,430	32,430	891,829	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	$ 17,894	$	10	$	$	$ 17,894	37
38	Paging Sys,Door Monitor,elevator,A/C	1994	6,642		10			6,642	38
39	Toaster,Fiber Optics,A/C,Signage,Counter,Bath	1995	25,208		10			25,208	39
40	Door Lock,Sink,NurseCall,A/C,Elevator,AlarmSys	1996	54,967		10			54,967	40
41	Vertical Blinds	1994	1,021		8			1,021	41
42	Landscape,room remodel,sink,fireplace,waterline	1997	27,864		10			27,864	42
43	CallSys,FireAlarm,ExpTank,DoorSec,Phone,Tub	1997	30,201		10			30,201	43
44	Landscape,Boiler,Door,Fire,Generator,Bath,Security,A/C,Cable,P	1998	63,791		10			63,791	44
45	Asphalt,DiningRm,Hall,Door,Bath,ElecEye	1999	12,436		10			12,436	45
46	Office,Lounge,Door,Fire,A/C,Sink,Tub	1999	34,425		10			34,425	46
47	Tempered Water System Redesigned	2000	14,400		20	720	720	12,000	47
48	Renovate Social Service Office	2000	3,422		10			3,422	48
49	Wanderguard Monitors	2000	2,591		8			2,591	49
50	Octel 100 Voicemail System	2000	6,260		5			6,260	50
51	Cable System Expansion	2000	1,844		5			1,844	51
52	Water System Installation	2001	41,500		20	2,075	2,075	33,027	52
53	Fire Alarms- Halls 4 & 5	2001	6,436		8			6,436	53
54	Air Condition Unit Hall 6	2001	3,424		10			3,424	54
55	Door Alarms - Hall 7	2001	2,757		8			2,757	55
56	Elevator Safety Edges	2002	3,245		10			3,245	56
57	Cable System Upgrade	2002	1,138		5			1,138	57
58	Room 601 Construction	2003	34,315		20	1,716	1,716	23,452	58
59	Room 306 Bathroom Conversion	2003	21,425		10			21,425	59
60	PT Room Divider Curtain	2003	2,589		10			2,589	60
61	Insinkerator Disposer for Kitchen	2003	1,048		5			1,048	61
62	New Exit Doors & Keypads	2003	9,618		7			9,618	62
63	Asbestos removal - Dining Rm Floor	2003	10,520		7			10,520	63
64	Vinyl Flooring in Dining Rm	2003	12,700		7			12,700	64
65	Expansion Dining Room	2004	2,612		15	174	174	2,239	65
66	Flooring for Elevator	2004	1,479		8			1,479	66
67	Walk-in Cooler	2004	8,043		10			8,043	67
68	Door Lock	2004	3,313		7			3,313	68
69	Telephone System	2004	16,115		10			16,115	69
70	TOTAL (lines 4 thru 69)		$ 3,624,448	$		$ 62,057	$ 62,057	$ 2,833,058	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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		$ 3,624,448	$		$ 62,057	$ 62,057	$ 2,833,058	1
2	Sealcoat Parking Lot	2004	2,479		3			2,479	2
3	Landscaping	2004	2,778		10			2,778	3
4	Renovation on resident rooms, hallways	2005	614,348		30	20,478	20,478	245,680	4
5	Roof replacement	2005	414,304		30	13,810	13,810	165,682	5
6	Resident room doors and refinishing	2005	6,164		30	205	205	2,364	6
7	Carpet and Tile Flooring	2005	20,031		15	1,335	1,335	15,356	7
8	Sprinkler system	2005	71,880		30	2,396	2,396	28,745	8
9	Lighting resident rooms and lobby.	2005	4,754		30	158	158	1,822	9
10	Privacy track, window rods, draperies	2005	5,678		7			5,678	10
11	Wiring Upgrade	2005	1,498		5			1,498	11
12	A/C condenser replacement	2005	4,775		15	318	318	3,685	12
13	Renovate Multi-Rm/Nurse Station	2005	85,586		30	2,853	2,853	32,821	13
14	Roof Replacement Dietary	2005	14,503		30	483	483	5,518	14
15	Chimney roofing work	2005	2,180		20	109	109	1,235	15
16	Install sink	2005	1,345		15	90	90	1,013	16
17	Transfer switch	2005	2,549		7			2,549	17
18	Sprinkler head	2005	1,458		30	49	49	541	18
19	Gas shut-off fire system	2005	2,600		30	87	87	986	19
20	Fire alarm	2005	11,087		15	739	739	8,281	20
21	Boiler pump	2005	3,986		10			3,986	21
22	Door	2006	1,379		10	114	114	1,379	22
23	Plumbing	2006	1,023		10	71	71	1,023	23
24	Carpeting	2006	2,618		10	20	20	2,618	24
25	Draperies	2006	174		7			174	25
26	Dining room wallpaper, lighting	2007	3,531		8			3,531	26
27	Public address system	2007	461		5			461	27
28	Room 701 flooring, lighting	2007	1,371		8			1,371	28
29	Sidewalk repairs	2007	3,054		10	305	305	2,913	29
30	Room 707 flooring, cabinetry	2007	1,208		8			1,208	30
31	Carpeting room 709	2007	591		8			591	31
32	Room 603 wallpaper, window coverings, lighting	2007	815		8			815	32
33	Room 612, lighting, flooring	2007	673		8			673	33
34	TOTAL (lines 1 thru 33)		$ 4,915,329	$		$ 105,677	$ 105,677	$ 3,382,512	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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		$ 4,915,329	$		$ 105,677	$ 105,677	$ 3,382,512	1
2	Room 604 window coverings	2007	55		1			55	2
3	Wallcoverings hall and 4 rooms	2007	1,400		8			1,400	3
4	Gate concrete pad	2007	725		3			725	4
5	Plumbing wing 1	2007	2,500		8			2,500	5
6	Fire alarm system upgrade	2007	4,150		8			4,150	6
7	Driveway curbing	2008	3,300		15	220	220	1,900	7
8	Plumbing, lighting, wallpaper	2008	7,686		8	35	35	7,686	8
9	Carpeting and door replacement	2008	1,200		8	6	6	1,200	9
10	Fireproofing and sprinklers	2008	33,288		15	2,219	2,219	19,661	10
11	Drainage work	2008	3,460		15	231	231	2,022	11
12	Eyewash station in kitchen	2008	1,250		8	50	50	1,250	12
13	Baseboards, wallpaper, carpeting	2008	1,825		10	186	186	1,610	13
14	Air conditioning repairs	2008	6,800		8	447	447	6,800	14
15	Elevator repairs	2008	1,206		3			1,206	15
16	Emergency exit lighting	2008	1,394		8	117	117	1,394	16
17	Bath tub fixture	2008	729		15	49	49	395	17
18	Wing 1 & Hall 1 draperies, wallpaper, lighting	2008	5,423		8	339	339	5,423	18
19	Draperies, wallpaper, & baseboards	2008	7,251		8	37	37	7,251	19
20	Contractor labor & materials for dining room	2008	12,087		8	57	57	12,087	20
21	Dining room tear-down, tiling, painting, trim	2008	5,716		8	24	24	5,716	21
22	Gazebo shingles & vinyl	2009	372		7	32	32	372	22
23	Chapel fans,shades,ceiling tile & fixtures	2009	9,289		5			9,289	23
24	Flooring for rooms 705, 605, 609	2009	1,915		10	192	192	1,367	24
25	Sod, mulch, road repairs	2010	2,170		15	145	145	876	25
26	Carpet, Vinyl, Blinds front office & restroom	2010	3,856		10	386	386	2,652	26
27	2 boiler pumps and douglas fir	2011	3,356		15	224	224	1,132	27
28	Circuit breaker, wall heater,wanderguard monitor, A/C	2011	4,138		15	218	218	1,447	28
29	Serenity walls, floor, electrical	2011	80,450		15	5,363	5,363	29,945	29
30	Physician office floor, wall, electrical	2011	7,767		15	518	518	2,634	30
31	Fire Safety doors	2012	7,730		15	515	515	2,275	31
32	Smoke dampers	2012	7,178		28	256	256	1,152	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,144,995	$		$ 117,543	$ 117,543	$ 3,520,084	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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		$ 5,144,995	$		$ 117,543	$ 117,543	$ 3,520,084	1
2	Wing 5 remodel - window replacement, painting, electrical, floorin	2012	27,808		10	2,781	2,781	13,524	2
3	Landscaping - Administration Building	2009	6,435		5			6,435	3
4	Administration Building	2009	1,710,294		40	42,757	42,757	199,533	4
5	Administration Building key fob entry system	2009	1,532		10	153	153	725	5
6	Administration Building wooden sign	2009	2,065		15	138	138	690	6
7	Wing 1 remodel - window replacement, painting, wallpaper, beadb	2013	32,884		10	3,288	3,288	11,782	7
8	Wing 6 & 7 remodel - painting, carpeting, room signs	2013	14,946		10	1,495	1,495	5,357	8
9	7 new Sprinkler Heads	2013	4,800		15	320	320	986	9
10	Boiler Repair	2013	1,826		15	122	122	447	10
11	Wanderguard System	2013	1,524		15	102	102	314	11
12	Construct Retaining Wall on Side Entrance	2014	8,145		15	543	543	1,312	12
13	Lighting Added at Circle Drive	2014	7,679		15	512	512	1,024	13
14	Resurface Circle Drive & Entrances, Add Additional Parking	2014	56,319		15	3,755	3,755	7,823	14
15	Wing 3, MPR & Hospice Room- Flooring, Painting Plumbing, Wa	2014	20,321		10	2,032	2,032	4,911	15
16	Wing 6 Tubroom Flooring	2014	2,561		10	256	256	555	16
17	Living Room & Entryway Renovation- Paint and Flooring	2014	32,971		5	6,594	6,594	13,738	17
18	Airconditioner Unit for Kitchen	2014	12,941		28	462	462	1,117	18
19	Repair Ceiling in Hall 3	2014	2,825		10	283	283	523	19
20	Repair Ceiling in Kitchen	2014	4,348		10	435	435	1,160	20
21	Remove Broken off Gutters from Main Sewer Line	2014	2,760		10	276	276	552	21
22	Relocate front entrance & build canopies	2015	195,421		30	6,514	6,514	11,416	22
23	Wing 1 Remodel - Cable wiring	2015	2,742		15	183	183	290	23
24	Wing 1 Remodel - Plumbing	2015	3,484		15	232	232	368	24
25	Wing 1 Remodel - Paint 4 Offices	2015	800		5	160	160	253	25
26	Wing 1 Remodel - Paint 4 Offices	2015	800		5	160	160	253	26
27	Wing 1 Remodel - Cabinetry	2015	1,121		5	224	224	355	27
28	Wing 1 Remodel - Offices Flooring Install	2015	1,182		5	236	236	374	28
29	Wing 1 Remodel - Paint and Drywall	2015	400		5	80	80	127	29
30	Wing 1 Remodel - Casing in Conference Rm	2015	523		5	105	105	166	30
31	Wing 1 Remodel - Phone wiring	2015	711		5	142	142	225	31
32	Wing 1 Remodel - Electrical wiring	2015	4,870		15	325	325	514	32
33	Wing 1 Remodel - Framing, Doors, and Hardware	2015	17,199		15	1,147	1,147	1,816	33
34	TOTAL (lines 1 thru 33)		$ 7,329,232	$		$ 193,355	$ 193,355	$ 3,808,749	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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 12D, Carried Forward		$ 7,329,232	$		$ 193,355	$ 193,355	$ 3,808,749	1
2	Wing 1 Remodel - New Blinds	2015	1,710		5	342	342	485	2
3	Foam Insulation	2015	1,220		15	81	81	128	3
4	Replacement Windows throughout and Foam Insulation	2015	30,850		5	6,170	6,170	8,741	4
5	Replace and Repair drywall in Beauty Shop	2015	4,452		5	890	890	1,261	5
6	Wall off hallway for Oxygen Storage Room	2015	19,624		15	1,308	1,308	1,744	6
7	New Wall Beadboard in Resident rooms	2015	2,363		5	473	473	552	7
8	New compressor in walk in freezer	2015	4,210		10	421	421	807	8
9	Surveillance System	2015	20,909		5	4,182	4,182	5,924	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17	Administrative Building Allocation-Land Improvements		86,706		Various	3,313	3,313	84,130	17
18	Administrative Building Allocation-Bldg Improvements		895		5	179	179	731	18
19	Administrative Building Allocation-Fixed Equipment		67,293		Various	3,085	3,085	48,094	19
20									20
21									21
22	Financial Statement Depreciation			157,755			(157,755)		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)		$ 7,569,464	$ 157,755		$ 213,799	$ 56,044	$ 3,961,346	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	$ 476,386	$	$ 23,564	$ 23,564	various	$ 349,613	71
72	Current Year Purchases	29,658		1,483	1,483	Various	1,483	72
73	Fully Depreciated Assets	122,160				various	122,160	73
74	Admin Bldg Equip Allocation	133,705		10,347	10,347	various	125,728	74
75	TOTALS	$ 761,909	$	$ 35,394	$ 35,394		$ 598,984	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)	$ 8,343,177	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 157,755	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 249,193	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 91,438	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,569,384	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	$ 17,776	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 21,141	$ 480	$ 17,776	91

G. Construction-in-Progress

	Description	Cost	
92	Work in Progress	$ 7,392	92
93			93
94			94
95		$ 7,392	95

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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

It is the policy of this facility to only hire certified nurses aides.

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$		$ 20,918	$		$ 20,918	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			8,838			8,838	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs			33,297	61		33,358	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				19,358		19,358	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 63,053	$ 19,419		$ 82,472	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 7/31/16 (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	$ 159,549	$ 159,549	1
2	Cash-Patient Deposits	6,677	6,677	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,043)	372,820	372,820	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,046	42,046	6
7	Other Prepaid Expenses	26,623	26,623	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany	1,386,184	1,386,184	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,993,899	$ 1,993,899	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	162,179	162,179	12
13	Land	2,750	2,750	13
14	Buildings, at Historical Cost	7,346,816	7,569,464	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	756,784	770,963	16
17	Accumulated Depreciation (book methods)	(4,385,461)	(4,569,384)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	473,730	473,730	21
22	Other Long-Term Assets (spe Ppd loan costs	218,121	218,121	22
23	Other(specify): Work in Progress	7,392	7,392	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,582,311	$ 4,635,215	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,576,210	$ 6,629,114	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 603,816	$ 603,816	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,677	6,677	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,186	76,186	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,236	49,236	32
33	Accrued Interest Payable	40,348	40,348	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	247,568	247,568	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,023,831	$ 1,023,831	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	698,252	698,252	39
40	Mortgage Payable	4,325,742	4,325,742	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,023,994	$ 5,023,994	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,047,825	$ 6,047,825	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 528,385	$ 581,289	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,576,210	$ 6,629,114	48

SEE ACCOUNTANTS' PREPARATION REPORT *(See instructions.)

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 908,624	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 908,623	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(380,238)	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)**	$ (380,238)	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)**	$ 528,385	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,119,232	1
2	Discounts and Allowances for all Levels	(772,343)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,346,889	3
	B. Ancillary Revenue		
4	Day Care	280	4
5	Other Care for Outpatients		5
6	Therapy	43,782	6
7	Oxygen	6,070	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 50,132	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	1,154	12
13	Barber and Beauty Care	1,330	13
14	Non-Patient Meals	36,919	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	299	19
20	Radiology and X-Ray	121	20
21	Other Medical Services	99,167	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 138,990	23
	D. Non-Operating Revenue		
24	Contributions	34,734	24
25	Interest and Other Investment Income***	23	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,757	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation Income	2,113	28
28a	See Attached Schedule 19A	4,953	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,066	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,577,834	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	625,570	31
32	Health Care	1,038,383	32
33	General Administration	730,077	33
	B. Capital Expense		
34	Ownership	258,805	34
	C. Ancillary Expense		
35	Special Cost Centers	213,009	35
36	Provider Participation Fee	92,228	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,958,072	40
41	**Income before Income Taxes (line 30 minus line 40)****	(380,238)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (380,238)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 667,371	44
45	Private Pay - Net Inpatient Revenue	1,468,070	45
46	Medicare - Net Inpatient Revenue	211,448	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,346,889	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Maple Lawn Health Center

Period Beginning **1/1/16**
Period End **7/31/16**

Schedule 19A

XVIII. Income Statement, Line 28a Other Revenue

Miscellaneous Revenue	1,055
Cottingham Revenue	3,898
Total Other Revenue	**4,953**

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

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	441	490	$ 16,928	$ 34.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,232	9,885	260,166	26.32	3
4	Licensed Practical Nurses	3,452	3,841	84,925	22.11	4
5	CNAs & Orderlies	28,634	31,301	396,885	12.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,103	2,283	32,810	14.37	8
9	Activity Director	759	851	13,035	15.32	9
10	Activity Assistants	2,866	3,069	34,278	11.17	10
11	Social Service Workers	412	447	9,815	21.96	11
12	Dietician	875	956	26,225	27.43	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,847	10,617	116,358	10.96	15
16	Dishwashers					16
17	Maintenance Workers	1,093	1,211	20,529	16.95	17
18	Housekeepers	5,543	6,178	76,242	12.34	18
19	Laundry	1,505	1,659	16,736	10.09	19
20	Administrator	940	1,084	70,778	65.29	20
21	Assistant Administrator	136	136	5,216	38.35	21
22	Other Administrative					22
23	Office Manager	1,142	1,261	51,626	40.94	23
24	Clerical	5,666	6,336	110,999	17.52	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	1,134	1,211	16,346	13.50	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	1,978	2,168	50,350	23.22	33
34	TOTAL (lines 1 - 33)	77,758	84,984	$ 1,410,247 *	$ 16.59	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	7,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	5,718	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	10,050	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	976	L11, C3	44
45	Social Service Consultant	Monthly	942	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,686		49

C. CONTRACT NURSES

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

Maple Lawn Health Center

Period Beginning **1/1/16**
Period End **7/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Transportation	195	211	2,279	10.80
Chaplain	1,081	1,172	29,877	25.49
Community Relations	542	604	14,857	24.60
Marketing/Dev	160	181	3,337	18.44
TOTAL	1,978	2,168	50,350	

Facility Name & ID Number: Maple Lawn Health Center # 0042424 Report Period Beginning: 1/1/16 Ending: 7/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
James Thomason	Administrator	0	$	70,778
Laura Collins	Asst Administrator	0		5,216
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	75,994

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type		Amount
Various	Legal Services	$	61,047
Various	Computer Service		8,915
Various	Accounting Services		26,987
Various	Computer Services		47,987
Various	Healthcare Consultant		1,050
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	145,986

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	67,296
Unemployment Compensation Insurance		10,475
FICA Taxes		102,189
Employee Health Insurance		54,000
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Pension Plan		10,338
Employee Life/Disability		3,980
Employee Physicals, Hep. B.		3,406
Employee Relations		224
Child Daycare		1,477
Other Empl Benefits		3,829
TOTAL (agree to Schedule V, line 22, col.8)	$	257,214

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

Description	Line #		Amount
		$	
N/A			
TOTAL		$	

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	
Advertising: Employee Recruitment		2,324
Health Care Worker Background Check		370
(Indicate # of checks performed 15)		
Patient Background Checks		
Illinois Health Care Association		4,312
Misc Dues & Licenses		3,533
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
TOTAL (agree to Sch. V, line 20, col. 8)	$	10,539

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		2,263
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	2,263

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Maple Lawn Health Center** **# 0042424** **Report Period Beginning: 1/1/16** **Ending: 7/31/16**

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. **4,312** **IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,110** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **92,228**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **38,073**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees