

		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: 0035527

Facility Name: Park Lawn Home

Address: 12615 South Kostner Avenue Alsip 60803
Number City Zip Code

County: Cook

Telephone Number: (708) 385-1982 Fax # (708) 385-8145

HFS ID Number:

Date of Initial License for Current Owners: 9-22-82

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ 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: Janice Leise Telephone Number: (708) 425-3344 Ext. 239
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 7-1-10 to 6-30-11 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)	10-26-11
	(Type or Print Name)	James R. Weise
	(Title)	Executive Director
Paid Preparer	(Signed)	
	(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 Park Lawn Home

0035527 Report Period Beginning: 7-1-10 Ending: 6-30-11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,818			4,818	13
14	TOTALS	4,818			4,818	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.00%

D. How many bed-hold days during this year were paid by the Department? 292 (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)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date _____ NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6-30-11 Fiscal Year: 6-30-11

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	29,919	517	1,040	31,476		31,476		31,476			1
2	Food Purchase		56,508		56,508		56,508		56,508			2
3	Housekeeping	1,599	2,276		3,875		3,875		3,875			3
4	Laundry		1,468		1,468		1,468		1,468			4
5	Heat and Other Utilities			1,229	1,229		1,229	12,377	13,606			5
6	Maintenance	15,452	620	5,339	21,411		21,411	33,819	55,230			6
7	Other (specify):* Plant Sec. & Pest Control		32		32		32		32			7
8	TOTAL General Services	46,970	61,421	7,608	115,999		115,999	46,196	162,195			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	13,767	7,455	5,640	26,862		26,862		26,862			10
10a	Therapy			1,760	1,760		1,760		1,760			10a
11	Activities		1,854		1,854		1,854		1,854			11
12	Social Services	4,226			4,226		4,226		4,226			12
13	CNA Training											13
14	Program Transportation	7,189	4,023	1,192	12,404		12,404		12,404			14
15	Other (specify):* See page 27	234,486		141	234,627		234,627		234,627			15
16	TOTAL Health Care and Programs	259,668	13,332	12,333	285,333		285,333		285,333			16
	C. General Administration											
17	Administrative	19,751			19,751		19,751	22,973	42,724			17
18	Directors Fees											18
19	Professional Services			8,777	8,777		8,777		8,777			19
20	Dues, Fees, Subscriptions & Promotions			2,035	2,035		2,035	(34)	2,001			20
21	Clerical & General Office Expenses	65,329		4,605	69,934		69,934		69,934			21
22	Employee Benefits & Payroll Taxes			85,400	85,400		85,400	(623)	84,777			22
23	Inservice Training & Education			781	781		781		781			23
24	Travel and Seminar			7	7		7		7			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,173	1,173		1,173	7,397	8,570			26
27	Other (specify):*											27
28	TOTAL General Administration	85,080		102,778	187,858		187,858	29,713	217,571			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	391,718	74,753	122,719	589,190		589,190	75,909	665,099			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,051	1,051		1,051	34,067	35,118			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			99	99		99	52,275	52,374			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			52,447	52,447		52,447		52,447			34
35	Rent-Equipment & Vehicles			4,768	4,768		4,768		4,768			35
36	Other (specify):*											36
37	TOTAL Ownership			58,365	58,365		58,365	86,342	144,707			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,241	34,241		34,241		34,241			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			34,241	34,241		34,241		34,241			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	391,718	74,753	215,325	681,796		681,796	162,251	844,047			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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				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				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	(623)	22		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	(34)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (657)		\$	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)			34
35	Other- Attach Schedule	162,908	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 162,908		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 162,251		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

Park Lawn Home

	ID#	0035527
Report Period Beginning:		7-1-10
Ending:		6-30-11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Allowable Depreciation from Related Party PLH	\$ 33,794	30	1
2	Allowable Interest from Related Party PLH	52,253	32	2
3	Allowable Related Party Interest PLA	22	32	3
4	Allowable Related Party Depreciation PLA	273	30	4
5	Allowable Related Party Utilities	12,377	5	5
6	Allowable Related Party Maintenance	33,819	6	6
7	Allowable Related Party Administrative	22,973	17	7
8	Allowable Related Party Insurance	7,397	26	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	162,908		49

Summary A

6-30-11

[illegible]

Summary B

6-30-11

[illegible]

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
				Park Lawn Assoc.	Oak Lawn	Support Organization
				Park Lawn Home, Inc.	Alsip	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$	Park Lawn Association, See Explanation on pare 5A and in notes		\$	\$	1
2	V								2
3	V				Park Lawn Home, Inc. See Explanation on page 5A and in notes.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jonathan Perry	BOD						1
2	Steve Janiszewski	BOD						2
3	Bonnie Price	BOD						3
4	Robert Schwartzers	BOD						4
5	Chuck DiNolfo	BOD						5
6	James Himmel	BOD						6
7	Pat O'Brien	BOD						7
8	Robert Barnes	BOD						8
9	Halima Jabulani	BOD						9
10	Cheri Boublis	BOD						10
11	Tom Olofsson	BOD						11
12	Maureen Reilly	BOD						12
13	Fred Zimmy	BOD						13
14	Dr. James Brodzinski	BOD						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

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	Not Applicable								\$		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 Park Lawn Home # 0035527 Report Period Beginning: 7-1-10 Ending: 6-30-11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1		See page 28.				\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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	Ford Credit		X	Ford Freestyle	\$331.93	4-8-06	\$ 17,632	\$	4-8-11	4.9000	\$ 22	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$331.93		\$ 17,632	\$			\$ 22	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 17,632	\$			\$ 22	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2010 report.			\$	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
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006		8	
	2007		9	
	2008		10	
	2009		11	
	2010		12	
Exempt				

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

FACILITY NAME	<u>Park Lawn Home</u>	COUNTY	<u>Cook</u>
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

	Exempt		
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	5,524	B. General Construction Type:	Exterior Concrete	Frame Aluminum gutter, downspout	Number of Stories	1
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C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facilities	77,381	1988	\$ 77,042	1
2					2
3	TOTALS	77,381		\$ 77,042	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	15			1991	\$ 676,975	\$ 27,079	25	\$ 27,079	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9	Garage		1995	18,306	732	25	732		11,776	9
10	Door East Side		2001	950	63	15	63		633	10
11	Bathroom Floor Tile		2001	625	42	15	42		441	11
12	Vinyl Flooring		2002	15,657	1,566	10	1,566		14,222	12
13	Storm Sewer		2002	3,780	378	10	378		3,433	13
14	4 Thermostats		2007	1,965	98	20	98		434	14
15	Sidewalks, Handrail & Door		2007	7,815	391	20	391		1,597	15
16	8 Toilets		2009	3,573	179	20	179		373	16
17	Galv Frames Shower		2009	1,833	91	20	91		183	17
18	Door Hardware		2009	3,370	168	20	168		350	18
19	Door Hardware Installation		2009	1,140	57	20	57		119	19
20	Wall Corner Guards		2009	1,050	70	15	70		134	20
21	Washroom wall & Floor Tile		2009	6,880	459	15	459		841	21
22	Additional Door Hardware		2009	732	37	20	37		68	22
23	4 Vapor Proof lights bath area		2010	1,075	108	10	108		153	23
24	Fence Repair		2010	1,260	116	10	116		116	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

*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 Park Lawn Home

0035527

Report Period Beginning:

7-1-10

Ending:

6-30-11

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 746,986	\$ 31,634		\$ 31,634	\$	\$ 34,873	70

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

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	\$ 13,162	\$ 1,819	\$ 1,819	\$	various	\$ 6,985	71
72	Current Year Purchases	6,758	342	342		various	342	72
73	Fully Depreciated Assets	27,957					27,957	73
74								74
75	TOTALS	\$ 47,877	\$ 2,161	\$ 2,161	\$		\$ 35,284	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	See notes page 25. A small % of a few vehicles			\$ 10,951	\$ 1,323	\$ 1,323	\$	5	\$ 6,950	76
77										77
78										78
79										79
80	TOTALS			\$ 10,951	\$ 1,323	\$ 1,323	\$		\$ 6,950	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)	\$ 882,856	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,118	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 77,107	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 2,217
- Description: Copiers \$760, PACE \$1457

(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	See attached listing page 26.		\$ 46.99	\$ 563	17
18					18
19					19
20					20
21	TOTAL		\$ 46.99	\$ 563	21

10. Effective dates of current rental agreement:

Beginning 7-1-10

Ending 6-30-11

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

	Fiscal Year Ending	Annual Rent
12.	06/30/2012	\$
13.	06/30/2013	\$
14.	06/30/2014	\$

* 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.

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

☐ 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

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

90 OJT

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Not Applicable	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$		\$	\$		\$	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$95,807	\$	1
2	Cash-Patient Deposits	93,597		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	209,137		5
6	Prepaid Insurance	51,281		6
7	Other Prepaid Expenses	212		7
8	Accounts Receivable (owners or related parties)	1,281,689		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,731,723	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	484,039		16
17	Accumulated Depreciation (book methods)	(349,949)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$134,090	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$1,865,813	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$223,236	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	95,574		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	547,394		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,792		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$870,996	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	878,574		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)	\$878,574	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$1,749,570	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$116,243	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$1,865,813	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 116,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 116,243	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		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)	\$	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)	\$ 116,243	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 596,787	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 596,787	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,732	10
11	CNA Training Reimbursements	5,920	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,652	23
	D. Non-Operating Revenue		
24	Contributions	79,072	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 79,072	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 683,511	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	115,999	31
32	Health Care	285,333	32
33	General Administration	187,858	33
	B. Capital Expense		
34	Ownership	58,365	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	34,241	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 681,796	40
41	Income before Income Taxes (line 30 minus line 40)**	1,715	41
42	Income Taxes	1,715	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Notes 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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	560	560	13,767	24.58	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	134	144	4,226	29.35	11
12	Dietician					12
13	Food Service Supervisor	347	416	6,539	15.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,940	2,307	23,380	10.13	15
16	Dishwashers					16
17	Maintenance Workers	1,010	2,143	15,452	7.21	17
18	Housekeepers	174	192	1,599	8.33	18
19	Laundry					19
20	Administrator	313	397	19,751	49.75	20
21	Assistant Administrator					21
22	Other Administrative	993	1,176	26,253	22.32	22
23	Office Manager	1,820	2,100	39,076	18.61	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	334	370	6,015	16.26	28
29	Resident Services Coordinator	589	686	22,562	32.89	29
30	Habilitation Aides (DD Homes)	14,130	16,120	171,510	10.64	30
31	Medical Records					31
32	Other Health C: Psychologist	46	46	3,715	80.76	32
33	Other(specify) See Page 28	2,562	3,097	37,873	12.23	33
34	TOTAL (lines 1 - 33)	24,952	29,754	\$ 391,718 *	\$ 13.17	34

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	52	\$ 1,040	1-3	35
36	Medical Director	29	3,600	9-3	36
37	Medical Records Consultant	4	140	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	32	1,760	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	22	5,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	139	\$ 12,040		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
James Weise	Executive Director	0	\$ 8,872	Workers' Compensation Insurance		\$ 6,912	IDPH License Fee	\$	
Julie Grounds	Deputy Ex. Dir.	0	10,879	Unemployment Compensation Insurance		6,377	Advertising: Employee Recruitment	33	
				FICA Taxes		27,345	Health Care Worker Background Check	157	
				Employee Health Insurance		42,123	(Indicate # of checks performed 5)		
				Employee Meals			Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*			Membership Dues	1,336	
				Employer Match		2,020	License Fees Other	146	
				Man Ben \$623 not included in total			Subscriptions & Texts	329	
TOTAL (agree to Schedule V, line 17, col. 1)							Public Relations	34	
(List each licensed administrator separately.)			\$ 19,751				Less: Public Relations Expense	(34)	
B. Administrative - Other							Non-allowable advertising	()	
Description			Amount				Yellow page advertising	()	
			\$				TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 84,777	\$ 2,001		
				TOTAL (agree to Schedule V, line 22, col.8)					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services							Out-of-State Travel	\$	
Vendor/Payee	Type		Amount						
James Himmel	Legal		\$ (544)				In-State Travel		
Cocalas Westberg Mommsen	Audit		846						
Kronos	Computer P/R		1,133						
ADP	Computer P/R		1,833						
Intelligent Solutions, Inc.	Data Processing		894						
Peter Ptak	Data Processing		759						
Comcast	Data Processing		959						
CDW	Data Processing		533				Seminar Expense		
Community Service Partners	Data Processing		2,338				ARC of Illinois Annual Convention	7	
Southwest Community Services	Data Processing		26						
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,777			\$	TOTAL	\$ 7	

*** Attach copy of IMRF notifications**

****See instructions.**

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? **No**
If YES, give association name and amount. _____
- (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? **various**
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ **862** 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. _____
- (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. \$ **34,241**
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. \$ **0** Has any meal income been offset against related costs? **0** Indicate the amount. \$ **0**
- (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? **0**
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 Personal use not permitted**
g. Does the facility transport residents to and from day training? **Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ **0**
- (17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Cocalas, Westberg, & Mommsen, LTD.**
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Related Party Adjustment						Park Lawn Home	
Lease Adjustment Management Benefits P/R & In Kind	ADJUSTMENT EXPLANATION 2010/2011 FY							
	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL
Total Lease	610,126	78,470	126,755	13,685	3,592	182,711	57,216	147,697
LESS: Community Lease	68,776	15198	28485	6,076	433	5,391	2,217	10,976
Related Organization	541,350	63,272	98,270	7,609	3,159	177,320	54,999	136,721
Interest & Depreciation Related Organization	569,355	16,602	80,247	6,239	2,485	92,508	86,343	284,932
Adjustment	28,005	(46,670)	(18,023)	(1,370)	(674)	(84,812)	31,344	148,211
Adjust Related Organization	569,355	16,602	80,247	6,239	2,485	92,508	86,343	284,932
Community Lease	68,776	15,198	28,485	6,076	433	5,391	2,217	10,976
Grand Total Allowable Lease	638,131	31,800	108,732	12,315	2,918	97,899	88,560	295,908
Other Adjustments								
Management Benefits	(8,100)	(1,089)	(2,010)	(353)	(243)	(1,669)	(623)	(2,113)
Public Relations	8,736	24	8,389	14	2	113	31	163
In Kind	0	0	0	0	0	0	0	0
	PLA	PLH						
Total Interest	209,260.50	52,253.54						
Total Depreciation	289,572.06	33,794.34		PLA Depreciation			Mortgage Interest	208,525.81
	498,832.56	86,047.88		Bldg. Depreciation		235,975.06	Vehicle Interes	734.69
PLH	86,047.88			Equipment Depreciation		53,597.00		209,260.50
	584,880.44					289,572.06		
Fundraising	-15,524.87							
	569,355.57							

D. Vehicle Depreciation			3	4	Current	%	5	6	Program %	7	8	9
1	2		Year	Cost	Book		Program	Straight	Straight	Adjustment	Life in	Accumulated
Use	Make, Model & Year		Acquired		Depreciation		% Depre.	Line Depr.	Line Dep.		Years	Depreciation
Activities	98 Econo Van	**	2005	\$7,333.50	\$0.00	4.68	\$0.00	\$0.00	\$0.00		5	\$7,333.50
Activities	05 Ford Free	**	2006	\$17,632.33	\$2,350.91	4.68	\$110.02	\$2,350.91	\$110.02		5	\$17,632.33
Activities	96 Merucry Sable	**	1996	\$19,929.00	\$0.00	4.68	\$0.00	\$0.00	\$0.00		5	\$19,929.00
Activities	11 Ford E350	**	2011	\$34,833.00	\$3,483.35	4.68	\$163.02	\$3,483.35	\$163.02		5	\$3,483.35
Activities	03 Ford Eldorado	*	2003	\$54,404.53	\$0.00	6.15	\$0.00	\$0.00	\$0.00		5	\$54,404.53
Activities	08 Chervrolet Braun	*	2007	\$32,564.00	\$6,512.80	6.15	\$400.54	\$6,512.80	\$400.54		5	\$23,337.53
Activities	08 Eldorado Aerotech	*	2008	\$52,873.00	\$10,574.60	6.15	\$650.34	\$10,574.60	\$650.34		5	\$33,486.23
Activities	09 Ford Eldorado Aerotech	*	2010	\$57,819.00	\$11,563.80	6.15	\$711.17	\$11,563.80	\$340.55		5	\$16,863.88
Activities	11 Ford E450 SuperDuty	*	2010	\$57,746.00	\$5,774.60	6.15	\$355.14	\$5,774.60	\$170.06		5	\$5,774.60
				\$335,134.36	\$40,260.06		\$1,323.92	\$40,260.06	\$1,323.92			\$159,606.47

* Owned by Park Lawn School Depreciation

\$1,050.88

** Owned by Park Lawn Association Depreciation

\$273.04

1323.92

	Program	Cost	Total Program	Program	Accumulated	Total
	Percentag		Cost	Percentag	Depreciation	Program
	e					Accum
						Depreciati
						on
* Owned by Park Lawn School Depreciation	0.0615	\$139,841.53	\$8,600.25	0.0615	\$111,228.29	\$6,840.54
** Owned by Park Lawn Association Depreciation	0.0468	\$44,894.83 \$2,350.91	\$184,736.36 \$10,951.16	0.0468	\$2,350.91 \$113,579.20	\$110.02 \$6,950.56

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn in unable to assign any vehicle to any one location, costs are assigned on a percentage of use basis. The vehicles with the 6.15% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

XII. C. Vehicle Rental

		1	2	3	Program	Program % of	4
		Use	#, Model & Year	Monthly Lease Pymt.	% of Use	Monthly Lease	Rental Expense for this Period
17	Activities		05 Ford Free	\$295.00	0.0468	\$13.81	\$165.67
	Activities		98 Econo Van	\$61.00	0.0468	\$2.85	\$34.26
	Activities		96 Mercury Sable	\$67.00	0.0468	\$3.14	\$37.63
	Activities		11 Ford E350	\$581.00	0.0468	\$27.19	\$326.29
21 Totals				\$1,004.00		\$46.99	\$563.85

Explanation Notes:

Detail of Other Lines over \$1,000 or multiple type of expenses on Page 3

Line 15 Column 1

Staff Trainer	\$2,623
QMRP	\$6,015
Psych	\$3,715
Resident Services Coor	\$22,562
Facility Services Coor	\$28,061
Hab Aides	\$171,510
	<u>\$234,486</u>

Schedule V. Page 3 & 4

Line 5 Column 7	Allowable Related Party Costs for Utilities	\$12,377
Line 6 Column 7	Allowable Related Party Costs for Maintenance	\$33,820
Line 17 Column 7	Allowable Related Party Costs for Administrative	\$35,351
Line 26 Column 7	Allowable Related Party Costs for Insurance	\$7,397
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	\$33,794
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLA	\$273
Line 32 Column 7	Allowable Related Party Costs for Interest PLA	\$22
Line 32 Column 7	Allowable Related Party Costs for Interest PLH	<u>\$52,254</u>
		\$175,288

Total Related Party Costs

Line 34 Column 4 Includes:

Office for Park Lawn School Program	\$8,026
Portion of Rent not in HUD Payments Park Lawn School costs	\$42,766
Equipment from Park Lawn Association	<u>\$1,499</u>
	\$52,291

Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	\$563
Equipment Rental	\$2,748
Pace Vehicle Rental	<u>\$1,457</u>
	\$4,768

Schedule VII. Part B Page 6

Park Lawn Association, Inc.		
Depreciation of Vehicles		\$273
Interest on Vehicles 735 X 3%		\$22
Total Park Lawn Association Costs		<u>\$295</u>
Park Lawn Homes, Inc.		
Utilities	\$12,377	
Maintenance	\$33,820	
Administration	\$22,973	
Taxes/Insurance	\$7,397	
Interest	\$52,253	
Depreciation Bldg. & Equipment	<u>\$33,794</u>	*
Total Park Lawn Homes Costs		<u>\$162,614</u>

* Building Depreciation does not include \$3,000 in Certification Fees

Total Related Party Adjustment on Page 5A Line 49

\$162,909

Schedule VIII. Part B

Central Office - 10833 S. Laporte Avenue occupies 1,717 square feet for Administration and Accounting and Bookkeeping.
This is 6.96% of the total square footage of 24,693.
These costs are collected in a temporary cost center and distributed out to programs on the basis of a predetermined appropriate distribution.

Administrative salaries are distributed as follows:

1. Executive Director - % of Budget
2. Acct/Bkcp - % of Budget
3. P/R Personnel - % of Staff

Schedule IX. Page 9

Line 15 \$22 is the allowable portion of program interest, see page 5 line 35

Schedule XI. Part D. Page 13

Line 46 Column 5 Includes only program portion of depreciation cost on vehicles. Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.

The vehicles with the 6.15% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

Schedule XII. Part C Page 14

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn in unable to assign any vehicle to any one location, costs are assigned on a percentage of use basis. The vehicles with the 6.15% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

Schedule XIII. Part B Page 15

Line 5 Column 4 Wages are included on page 20 line 33.

Schedule XVIII. Page 19

Does this agree with taxable income (Loss) per Federal Income Tax return? Federal Income Tax return is not completed until December of the current year.

Schedule XX. Page 23

Question 12 Allocated based on hours worked per department.

Question 15 No Employee meals are served.