

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0027078

Facility Name: Park Lawn Center

Address: 5831 West 115th Street Alsip 60803
Number City Zip Code

County: Cook

Telephone Number: (708) 396-1117 Fax # (708) 396-1186

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 7-1-11 to 6-30-12 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) 10-26-12 (Date)

(Type or Print Name) James R. Weise

(Title) Executive Director

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Park Lawn Center# 0027078 Report Period Beginning: 7-1-11 Ending: 6-30-12

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	41	Intermediate/DD	41	15,006	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	15,006	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	14,282			14,282	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,282			14,282	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.18%

D. How many bed-hold days during this year were paid by the Department?

252 (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?

YesG. 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 09/22/82

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 09/22/82NO ☐

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

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 6-30-12Fiscal Year: 6-30-12

* 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	142,217	4,485	7,410	154,112		154,112		154,112			1
2	Food Purchase		193,324		193,324		193,324		193,324			2
3	Housekeeping	49,982	9,503		59,485		59,485		59,485			3
4	Laundry	31,930	10,607		42,537		42,537		42,537			4
5	Heat and Other Utilities			59,941	59,941		59,941		59,941			5
6	Maintenance	14,695	25,941	29,398	70,034		70,034		70,034			6
7	Other (specify):*	21,084	3,630		24,714		24,714		24,714			7
8	TOTAL General Services	259,908	247,490	96,749	604,147		604,147		604,147			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	306,613	65,592	24,875	397,080		397,080		397,080			10
10a	Therapy			7,315	7,315		7,315		7,315			10a
11	Activities	35,144	621		35,765		35,765		35,765			11
12	Social Services	11,714			11,714		11,714		11,714			12
13	CNA Training											13
14	Program Transportation		8,539	3,629	12,168		12,168		12,168			14
15	Other (specify):*	799,210			799,210		799,210		799,210			15
16	TOTAL Health Care and Programs	1,152,681	74,752	44,219	1,271,652		1,271,652		1,271,652			16
	C. General Administration											
17	Administrative	34,641			34,641		34,641		34,641			17
18	Directors Fees											18
19	Professional Services			27,699	27,699		27,699		27,699			19
20	Dues, Fees, Subscriptions & Promotions			4,980	4,980		4,980	(135)	4,845			20
21	Clerical & General Office Expenses	126,262	24,854		151,116		151,116		151,116			21
22	Employee Benefits & Payroll Taxes			345,316	345,316		345,316	(2,813)	342,503			22
23	Inservice Training & Education			3,258	3,258		3,258		3,258			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			20,548	20,548		20,548		20,548			26
27	Other (specify):*											27
28	TOTAL General Administration	160,903	24,854	401,801	587,558		587,558	(2,948)	584,610			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,573,492	347,096	542,769	2,463,357		2,463,357	(2,948)	2,460,409			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			4,937	4,937	(1,269)	3,668	169,939	173,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,180	2,180		2,180	138,138	140,318			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			131,048	131,048		131,048	(131,048)				34
35	Rent-Equipment & Vehicles			17,527	17,527		17,527	(5,904)	11,623			35
36	Other (specify):* Unallowed Depreciation					1,269	1,269		1,269			36
37	TOTAL Ownership			155,692	155,692		155,692	171,125	326,817			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			141,893	141,893		141,893		141,893			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			141,893	141,893		141,893		141,893			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,573,492	347,096	840,354	2,760,942		2,760,942	168,177	2,929,119			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(2,813)	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	(135)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,948)		\$	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	171,125	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 171,125		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 168,177		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 Center

ID#

0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Allowable Depreciation from Related Party	\$ 169,939	30	1
2	Allowable Interest from Related Party	138,138	32	2
3	Rent-Facility & Grounds	(131,048)	34	3
4	Rent-Equipment & Vehicles	(5,904)	35	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	171,125		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-11 Ending: 6-30-12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(135)	0	0	0	0	0	0	0	0	0	0	(135)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,813)	0	0	0	0	0	0	0	0	0	0	(2,813)	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	(2,948)	0	0	0	0	0	0	0	0	0	0	(2,948)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(2,948)	0	0	0	0	0	0	0	0	0	0	(2,948)	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	169,939	0	0	0	0	0	0	0	0	0	0	169,939	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	138,138	0	0	0	0	0	0	0	0	0	0	138,138	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(131,048)	0	0	0	0	0	0	0	0	0	0	(131,048)	34
35	Rent-Equipment & Vehicles	(5,904)	0	0	0	0	0	0	0	0	0	0	(5,904)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	171,125	0	0	0	0	0	0	0	0	0	0	171,125	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	168,177	0	0	0	0	0	0	0	0	0	0	168,177	45

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 Organizatio

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 page 5A		\$	\$	1
2	V								2
3	V								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	Robert Schwartzers	BOD						3
4	Bonnie Price	BOD						4
5	Bill Downs	BOD						5
6	James Himmel	BOD						6
7	Marilyn Wnuk	BOD						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

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 Center # 0027078 Report Period Beginning: 7-1-11 Ending: 6-30-12

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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		See page 27.				\$	\$			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	Private Bank		X	Mortgage	interest	12-29-05	\$ 3,000,000	\$ 2,758,207	12-15-12	4.8750	\$ 138,138	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 3,000,000	\$ 2,758,207			\$ 138,138	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 2,758,207			\$ 138,138	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 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
Not Applicable					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Park Lawn Center

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0027078

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()
FAX #: ()

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	Not Applicable	\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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:	24,891	B. General Construction Type:	Exterior	Brick & Aluminium	Frame	Number of Stories	2
------------------------	---------------	--------------------------------------	-----------------	------------------------------	--------------	--------------------------	----------

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: **Completely Amortized 6-30-08** 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	124,955	1981	\$ 190,000	1
2					2
3	TOTALS	124,955		\$ 190,000	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	41		1982		\$ 210,000	\$ 6,000	35	\$ 6,000		\$ 178,636
5										
6										
7										
8										
	Improvement Type**									
9	Plumbing, Heat & AC			1982	165,500	4,729	35	4,729		141,870
10	Electric & Fixtures			1982	81,400	2,326	35	2,326		69,780
11	Elevator			1982	33,385	954	35	954		28,620
12	Concrete			1982	43,171	1,233	35	1,233		21,194
13	Sprinklers			1982	22,085	631	35	631		18,910
14	Bath. Access.			1982	2,450	70	35	70		2,100
15	Construction Int			1982	18,357	525	35	525		15,750
16	Carpentry			1982	23,800	680	35	680		20,400
17	Windows			1982	33,088	945	35	945		28,353
18	Ceramic Tile			1982	10,621	303	35	303		9,090
19	Painting			1982	10,166	290	35	290		8,700
20	Various Construction Materials			1982	75,966	2,170	35	2,170		65,100
21	Permits			1982	1,803	52	35	52		1,560
22	Architect Fee			1982	29,577	844	35	844		25,320
23	Construction Manager			1982	40,000	1,143	35	1,143		34,290
24	Demolition			1982	6,858	196	35	196		5,880
25	Windows			1983	4,258		25			4,258
26	Sewer & Sump Pump			1983	4,933		10			4,933
27	Windows			1986	850		25			850
28	Generator			1986	15,785		20			15,785
29	Fence/Gate			1993	2,053		10			2,053
30	Roof Repair			1997	26,382	146	15	146		26,382
31	Tile Main area and Floor Patch			2001	5,857	145	10	145		5,857
32	Compressor			2004	2,475	165	15	165		1,320
33	4 Stage Chiller			2005	1,285	85	15	85		674
34	Elevator Pump			2005	6,200	620	10	620		3,513
35	General Contractor Job Superintendent			2007	180,564	4,514	40	4,514		185,078
36	General Contractor Fees			2007	210,949	5,274	40	5,274		27,688

*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

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	Ins & Permits	2007	\$ 184,211	\$ 4,605	40	\$ 4,605	\$	\$ 24,177	37
38	Estimate Contingency	2007	1,471	37	40	37		194	38
39	Roofing	2007	185,247	4,631	40	4,631		24,313	39
40	Metal Wall Panels	2007	17,760	444	40	444		2,331	40
41	Sun Screens	2007	46,408	1,160	40	1,160		6,090	41
42	HVAC	2007	230,756	5,769	40	5,769		30,287	42
43	Electrial	2007	366,412	9,160	40	9,160		48,090	43
44	Final Cleaning	2007	1,145	29	40	29		152	44
45	Selective Demolition	2007	39,425	986	40	986		5,176	45
46	Earthwork	2007	103,726	2,593	40	2,593		13,613	46
47	Asphalt Paving	2007	56,525	1,413	40	1,413		7,415	47
48	Fencing	2007	12,113	303	40	303		1,591	48
49	Landscapomg	2007	23,679	592	40	592		3,108	49
50	Concrete	2007	148,644	3,716	40	3,716		19,509	50
51	Steel	2007	18,829	471	40	471		2,472	51
52	Carpentry	2007	592,248	14,806	40	14,806		78,791	52
53	Millwork	2007	35,126	878	40	878		4,610	53
54	Drywall & acoustical	2007	233,229	5,831	40	5,831		30,612	54
55	Calking	2007	4,232	106	40	106		556	55
56	Door & Hardware	2007	77,373	1,934	40	1,934		10,154	56
57	R/R Coiling Doors	2007	3,148	79	40	79		414	57
58	Overhead Doors	2007	3,450	86	40	86		452	58
59	Aluminum Entrances	2007	67,203	1,680	40	1,680		8,820	59
60	Wood Windows	2007	82,549	2,064	40	2,064		10,836	60
61	Tile & Carpet	2007	126,869	3,172	40	3,172		16,653	61
62	Painting	2007	47,690	1,192	40	1,192		6,258	62
63	Toilet Acc/Floor Mat/ Fire Ext/ Tack board	2007	15,955	399	40	399		1,995	63
64	Aceovyn Wall Protection	2007	20,486	512	40	512		2,688	64
65	Fire Protection	2007	112,086	2,802	40	2,802		14,711	65
66	Plumbing	2007	387,850	9,696	40	9,696		50,904	66
67	Low Voltage	2007	20,482	512	40	512		2,688	67
68	Fire Hydrant	2007	9,975	249	40	249		1,308	68
69	Two Monument Signs	2007	4,750	119	40	119		624	69
70	TOTAL (lines 4 thru 69)		\$ 4,550,870	\$ 116,066		\$ 116,066	\$	\$ 1,385,536	70

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

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

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		\$ 4,550,870	\$ 116,066		\$ 116,066	\$	\$ 1,385,536	1
2	<u>Metal Studs</u>	2007	13,225	331	40	331		1,737	2
3	<u>Architect</u>	2007	348,281	8,707	40	8,707		45,712	3
4	<u>Legal</u>	2007	4,095	102	40	102		536	4
5	<u>Soil Boring</u>	2007	1,200	30	40	30		158	5
6	<u>Survey</u>	2007	2,300	58	40	58		304	6
7	<u>Phone System</u>	2007	12,262	307	40	307		1,611	7
8	<u>Title Company Fees</u>	2007	5,410	135	40	135		709	8
9	<u>General Contractor Job Superintendent</u>	2007	22,050	551	40	551		2,480	9
10	<u>General Contractor Fees</u>	2007	71,712	1,793	40	1,793		8,068	10
11	<u>Roofing</u>	2008	53,578	1,339	40	1,339		5,926	11
12	<u>Sun Screens</u>	2008	27,467	687	40	687		3,091	12
13	<u>HVAC</u>	2008	42,548	1,064	40	1,064		4,762	13
14	<u>Electrical</u>	2008	42,114	1,053	40	1,053		4,738	14
15	<u>Selective Demolition</u>	2008	2,018	50	40	50		225	15
16	<u>Earthwork</u>	2008	5,459	136	40	136		612	16
17	<u>Asphalt Paving</u>	2008	2,975	74	40	74		333	17
18	<u>Fencing</u>	2008	638	16	40	16		72	18
19	<u>Landscaping</u>	2008	8,958	224	40	224		1,051	19
20	<u>Concrete</u>	2008	7,823	196	40	196		882	20
21	<u>Steel</u>	2008	3,641	91	40	91		410	21
22	<u>Carpntry</u>	2008	31,944	799	40	799		3,595	22
23	<u>Millwork</u>	2008	11,554	289	40	289		1,300	23
24	<u>Drywall & Acoustical</u>	2008	54,781	1,370	40	1,370		6,165	24
25	<u>Doors & Hardware</u>	2008	5,007	125	40	125		562	25
26	<u>Aluminum Entrances</u>	2008	8,517	213	40	213		958	26
27	<u>Wood Windows</u>	2008	1,395	35	40	35		157	27
28	<u>Tile & Carpet</u>	2008	12,794	320	40	320		1,440	28
29	<u>Painting</u>	2008	23,111	578	40	578		2,775	29
30	<u>Toilet Acc/Floor/Mat/Fire Ext/ Tack Board</u>	2008	2,465	62	40	62		279	30
31	<u>Acrovyn Wall Protection</u>	2008	472	12	40	12		54	31
32	<u>Fire Protection</u>	2008	37,852	946	40	946		4,257	32
33	<u>Plumbing</u>	2008	41,841	1,043	40	1,043		4,756	33
34	TOTAL (lines 1 thru 33)		\$ 5,460,357	\$ 138,802		\$ 138,802	\$	\$ 1,495,251	34

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

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		\$ 5,460,357	\$ 138,802		\$ 138,802	\$	\$ 1,495,251	1
2	Low Voltage	2008	23,516	588	40	588		1,764	2
3	Fire Hydrant	2008	525	13	40	13		39	3
4	Two Monument Signs	2008	12,250	306	40	306		918	4
5	Metal Studs	2008	4,295	107	40	107		321	5
6	Architect	2008	1,969	49	40	49		147	6
7	Phone System	2008	10,053	251	40	251		753	7
8	Aquarium	2009	7,827	783	10	783		2,349	8
9	Artwork	2009	1,510	151	10	151		453	9
10	Dedication Sign	2009	2,553	54	40	54		162	10
11	Two Electric Heaters	2009	1,121	28	40	28		84	11
12	Vinyl Tile Front Entrance	2009	1,468	37	40	37		111	12
13	Wallcovering & Chair Rail	2099	3,992	100	40	100		300	13
14	Masonary Restoration	2009	3,685	184	20	184		552	14
15	Tuckpointing Bldg.	2010	9,800	490	20	490		1,307	15
16	Parking Lot Lighting	2010	3,480	174	20	174		421	16
17	Pump Work	2010	1,522	101	15	101		244	17
18	Two Marley Heaters	2010	2,618	261	10	261		831	18
19	Door Hardware	2010	1,488	74	20	74		148	19
20	Crack filling/sealcoating of lot	2010	4,747	475	10	475		910	20
21	Exhaust Fan add on Elevator Room	2011	2,775	278	10	278		347	21
22	Canopy Sprinkler Installation	2011	9,290	619	15	619		671	22
23	Completion of River Rock to CR Drive	2011	1,097	110	10	110		110	23
24	Redo Center Landscapting	2011	5,869	261	15	261		261	24
25	Water Heater	2012	3,082	77	10	77		77	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,580,889	\$ 144,373		\$ 144,373	\$	\$ 1,508,531	34

**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	\$ 298,426	\$ 24,115	\$ 24,115	\$	various	\$ 152,476	71
72	Current Year Purchases	11,698	814	814		various	814	72
73	Fully Depreciated Assets	141,866					141,866	73
74								74
75	TOTALS	\$ 451,990	\$ 24,929	\$ 24,929	\$		\$ 295,156	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 page 25.			\$ 38,590	\$ 4,305	\$ 4,305	\$	5	\$ 26,510	76
77										77
78										78
79										79
80	TOTALS			\$ 38,590	\$ 4,305	\$ 4,305	\$		\$ 26,510	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)	\$ 6,261,469	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,607	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,607	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)	\$ 1,830,197	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

10. Effective dates of current rental agreement:

Beginning

7-1-11

Ending

6-30-12

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

	Fiscal Year Ending	Annual Rent
12.	06/30/2013	\$ 125,592
13.	06/30/2014	\$ 125,592
14.	06/30/2015	\$ 125,592

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:
- \$ 11,607
- Description:
- PACE \$4857, Copier \$6750

(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		\$ 375.96	\$ 4,512	17
18					18
19					19
20					20
21	TOTAL		\$ 375.96	\$ 4,512	21

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

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

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 CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA90 OJT

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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(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	\$ 97,828	\$	1
2	Cash-Patient Deposits	87,743		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,777		6
7	Other Prepaid Expenses	13,042		7
8	Accounts Receivable (owners or related parties)	1,259,710		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,502,100	\$	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	542,376		16
17	Accumulated Depreciation (book methods)	(398,120)		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)	\$ 144,256	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,646,356	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 164,955	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	87,705		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	373,198		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,967		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)	\$ 636,825	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	893,288		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)	\$ 893,288	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,530,113	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 116,243	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,646,356	\$	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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 2,380,379	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,380,379	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	4,667	10	
11 CNA Training Reimbursements	15,442	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)	\$ 20,109	23	
D. Non-Operating Revenue			
24 Contributions	363,983	24	
25 Interest and Other Investment Income***		25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 363,983	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)	\$ 2,764,471	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	604,147	31	
32 Health Care	1,271,652	32	
33 General Administration	587,558	33	
B. Capital Expense			
34 Ownership	155,692	34	
C. Ancillary Expense			
35 Special Cost Centers		35	
36 Provider Participation Fee	141,893	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,760,942	40	
41 Income before Income Taxes (line 30 minus line 40)**	3,529	41	
42 Income Taxes	3,529	42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	43	

III. Net Inpatient Revenue detailed by Payer Source		
44 Medicaid - Net Inpatient Revenue	\$	44
45 Private Pay - Net Inpatient Revenue		45
46 Medicare - Net Inpatient Revenue		46
47 Other-(specify)		47
48 Other-(specify)		48
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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	1,712	2,053	\$ 60,991	\$ 29.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,760	4,195	114,449	27.28	3
4	Licensed Practical Nurses	4,314	5,058	131,173	25.93	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	2,993	3,367	35,144	10.44	10
11	Social Service Workers	369	384	11,714	30.51	11
12	Dietician					12
13	Food Service Supervisor	1,232	1,581	24,770	15.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,241	11,299	117,447	10.39	15
16	Dishwashers					16
17	Maintenance Workers	791	873	14,695	16.83	17
18	Housekeepers	4,596	5,160	49,982	9.69	18
19	Laundry	1,870	2,085	31,930	15.31	19
20	Administrator	446	685	34,641	50.57	20
21	Assistant Administrator					21
22	Other Administrative	2,620	3,132	76,770	24.51	22
23	Office Manager	1,626	2,192	41,460	18.91	23
24	Clerical	554	611	8,032	13.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,323	7,327	113,580	15.50	28
29	Resident Services Coordinator	681	772	27,760	35.96	29
30	Habilitation Aides (DD Homes)	40,666	54,525	638,840	11.72	30
31	Medical Records					31
32	Other Health Care(specify)	59	104	8,495	81.68	32
33	Other(specify)	2,481	2,705	31,619	11.69	33
34	TOTAL (lines 1 - 33)	87,334	108,108	\$ 1,573,492 *	\$ 14.55	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	72	\$ 7,410	1-3	35
36	Medical Director	29	8,400	9-3	36
37	Medical Records Consultant	10	350	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	133	7,315	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	24	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	268	\$ 29,475		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	288	\$ 17,633	10-3	50
51	Licensed Practical Nurses	24	892	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	312	\$ 18,525		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

0027078

Report Period Beginning: 7-1-11

Page 21

Park Lawn Center

Ending: 6-30-12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James R. Weise	Executive Director	0	\$ 30,037
Julie Grounds	Deputy Ex. Dir.	0	4,604
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 34,641

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
James Himmel	Legal	\$ 17
Cocalas Westberg & Mommsen	Audit	2,870
Kronos	Computer P/R	6,211
ADP	Computer P/R	5,860
Community Services Partners	Data Processing	10,879
Peter Ptak	Data Processing	403
Sage Software	Data Processing Software	396
Wessels Sherman	Legal H-R	196
Comcast	Internet	867
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 27,699

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 33,620
Unemployment Compensation Insurance	27,646
FICA Taxes	121,397
Employee Health Insurance	154,773
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer Match	5,067
Man Ben \$2813 not included in total	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 342,503

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	603
Health Care Worker Background Check (Indicate # of checks performed 59)	593
Patient Background Checks	
Membership Dues	3,163
License Fees Other	231
Subscriptions & Texts	255
Public Relations	135
Less: Public Relations Expense	(135)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,845

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
	0
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

\$ 24,990
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.

\$ 141,893

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 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?

No

Attach invoices and a summary of services for all architect and appraisal fees.

	Related Party Adjustment						Park Lawn Center	
Lease Adjustment Management Benefits P/R & In Kind	ADJUSTMENT EXPLANATION 2011/2012 FY							
	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL
Total Lease	635,345	83,104	135,623	15,724	3,647	189,465	59,238	148,544
LESS: Community Lease	70,158	16394	26716	6,679	0	4,250	4,511	11,608
Related Organization	565,187	66,710	108,907	9,045	3,647	185,215	54,727	136,936
Interest & Depreciation Related Organization	584,273	15,842	80,632	6,275	2,493	107,519	86,158	285,354
Adjustment	19,086	(50,868)	(28,275)	(2,770)	(1,154)	(77,696)	31,431	148,418
Adjust Related Organization	584,273	15,842	80,632	6,275	2,493	107,519	86,158	285,354
Community Lease	70,158	16,394	26,716	6,679	0	4,250	4,511	11,608
Grand Total Allowable Lease	654,431	32,236	107,348	12,954	2,493	111,769	90,669	296,962
Other Adjustments								
Management Benefits	(10,788)	(1,407)	(2,702)	(437)	(329)	(2,270)	(830)	(2,813)
Public Relations	7,900	331	6,761	322	321	22	8	135
In Kind	0	0	0	0	0	0	0	0
	PLA	PLH						
Total Interest	209,787.83	51,513.40						
Total Depreciation	303,047.86	34,342.23		PLA Depreciation			Mortgage Interest	208,509.83
	512,835.69	85,855.63		Bldg. Depreciation		249,530.31	Vehicle Interest	1278
PLH	85,855.63			Equipment Depreciation		53,517.55		209,787.83
	598,691.32					303,047.86		
Fundraising	-14,418.91							

584,272.41

1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Prog. % of Depreciation	6 Straight Line Depreciation	Program % of Straight Line Depr.	7 Adjustments	8 Life in Years
Medical Appts.	96 Mercury Sable	**	1996	\$19,929.00	0	9.1	0	0	0		5
Medical Appts.	98 Econo Van	**	2004	\$7,333.50	\$0.00	9.1	\$0.00	\$0.00	\$0.00		5
Medical Appts.	2005 Free Ford	**	2006	\$17,632.00	\$0.00	9.1	\$0.00	\$0.00	\$0.00		5
Medical Appts.	05 Ford Taurus	**	2007	\$10,922.00	\$727.85	9.1	\$66.23	\$2,184.46	\$66.23	-	5
Medical Appts.	2011 Ford E 350	**	2011	\$34,833.50	\$6,966.70	9.1	\$633.97	\$6,966.70	\$633.97	-	5
Medical Appts.	01 Light Duty Ford Eldorado *		2002	\$44,353.00	\$0.00		\$0.00	\$0.00	\$0.00	-	5
Medical Appts.	02 Mini Van Chevy Venture *		2002	\$33,545.00	\$0.00		\$0.00	\$0.00	\$0.00		5
Medical Appts.	03 Ford Eldorado	*	2003	\$54,404.53	\$0.00		\$0.00	\$0.00	\$0.00		5
Medical Appts.	2008 Chevy Braun	*	2007	\$32,564.00	\$6,512.80	8	\$521.02	\$6,512.80	\$521.02		5
Medical Appts.	2008 Eldorado Aerotech	*	2008	\$52,873.00	\$10,574.60	8	\$845.97	\$10,574.60	\$845.97		5
Medical Appts.	Ford Eldorado Aerotech	*	2009	\$57,819.00	\$11,563.80	8	\$925.10	\$11,563.80	\$925.10		5
Medical Appts.	2011 Ford E450 Super Duty *		2011	\$57,746.00	\$11,549.20	8	\$923.94	\$11,549.20	\$923.94		5
Medical Appts.	2012 Ford EIDroado Bus	*	2012	\$58,337.00	\$4,861.42	8	\$388.91	\$4,861.42	\$388.91		5
				\$482,291.53	\$52,756.37		\$4,305.15	\$54,212.98	\$4,305.15		
		*									
		**									
	* Owned by Park Lawn School			Depreciation	\$3,604.95						
	** Owned by Park Lawn Assoc.			Depreciation	<u>\$700.20</u>						
					\$4,305.15						

Due to the number of Participants transported in all Park Lawn Programs, 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 8% usage are almost all wheel chair accessible and must be used when transporting wheel chair bound participants.

	Program %	Cost	Program Cost	Program %	Accum. Deprec	Program Accum Deprec.
Owned by Park Lawn School	0.08	\$391,641.53	\$31,331.32	0.08	\$256,826.59	\$20,546.13
Owned by Park Lawn Assoc.	0.091	\$90,650.00	\$8,249.15	0.091	\$65,538.98	\$5,964.05
			<u>\$39,580.47</u>			<u>\$26,510.17</u>

9
Accumulated
Depreciation

\$19,929.00
\$7,333.50
\$17,632.33
\$10,194.15
\$10,450.00
\$44,353.00
\$33,545.00
\$54,404.53
\$29,850.33
\$44,060.83
\$28,427.68
\$17,323.80
\$4,861.42
\$322,365.57

XII. C. Vehicle Rental

1	2	3	Program	Program % of	4
Use	Make, Model & Year	Monthly Lease Pymt	% of Use	Monthly Lease	Rental Expense for this Period
Activities	2005 Free Ford	\$285.00	0.241	68.69	\$824.22
Activities	2005 Ford Taurus	\$285.00	0.241	68.69	\$824.22
Activities	96 Mercury Sable Station Wagon	\$200.00	0.241	48.20	\$578.40
Activities	1998 Econo Van	\$200.00	0.241	48.20	\$578.40
Activities	2011 Ford E 350	\$590.00	0.241	142.19	\$1,706.28
21 Totals		\$1,560.00		375.96	\$4,511.52

Explanation Notes:

Schedule V. Page 3 Details of Other Lines over \$1,000 or with multiple type of expenses

Line 7 Column 2	
Cable TV	774
Pest Control	\$1,574
Plant Security	<u>\$1,282</u>
	\$3,630
Line 15 Column 1	
Staff Trainer	\$10,535
QMRP	\$113,580
Res. Serv. Coord.	\$27,760
Hab. Aides	\$638,840
Psychiatrist	<u>\$8,495</u>
	\$799,210

Schedule V. Page 4
Line 30 Column 5 To move depreciation of \$1,269 on assets acquired with Capital Acquisition Grant from DMH which is unallowed so it won't be included in depreciation number that we need to tie to.

Line 36 Column 5 Unallowed Capital Acquisition Grant Depreciation identified

Line 30 Column 7 Related Party Allowable Depreciation, Public Aid Depreciation is less than Book Depreciation.	
Building Depreciation	\$146,411
Vehicle Depreciation	\$700.00
Equipment Depreciation	<u>\$22,828.00</u>
	\$169,939.00

Line 35 Column 8 Community Leased equipment: Copier \$6,750, PACE \$4,857

Schedule VII. Part B	
Park Lawn Association, Inc.	
Building Rental not allowed	(\$131,048)

Equipment Rental not allowed			(\$5,904)
Allowable Building Interest			\$138,138
Depreciation Allowed			
Building	\$146,411		
Vehicle Depreciation	\$700		
Equipment	<u>\$22,828</u>		
Total Depreciation Allowed *	\$169,939	<u>\$169,939</u>	
* Based on Public Aid allowable Depreciation Book Depreciation on building is \$2,400 higher than Public Aid allowable depreciation			
Total Related Party Adjustment Detailed on Page 5A line 49			\$171,125.00

Schedule VIII. Part B

Central Office - 10833 S. Laporte Avenue occupies 1,717 square feet Administration and Accounting and Bookkeeping.
This is 6.96% of Total square Footage of 24,693.
These costs are distributed to each program on the percentage of budget.
The Administrative salaries are distributed on the percentage of budget basis.

Schedule IX Interest Expense	Column 10	
Private Bank	This programs mortgage interest allowed from related party	\$138,138.00

Schedule XI. Part D

Line 46 Column 5 Includes only the program portion of depreciation costs on vehicles.
Due to the number of Participants transported in all Park Lawn Programs, 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 8% usage are almost all wheel chair accessible and must be used when transporting wheel chair bound participants.

Schedule XII Part C Page 14

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. These vehicle lease costs are only program portion and are for activities.
A detailed schedule of proration is on Page 26.

Schedule XIII. 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.

Schdeule XVIII. Page 20 Line 33	Hrs. Worked Hrs. Paid & Accrued		
Drivers	1993	2129	\$21,084
Trainer	488	576	\$10,535
	2481	2705	\$31,619

Schedule XX. Page 23

Question 15 No Employee meals are served