

		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: 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:

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
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
	(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: 7-1-11 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		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,490	6
7	15	TOTALS	15	5,490	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	5,138			5,138	13
14	TOTALS	5,138			5,138	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.59%

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

279 (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/AF. 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 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: 6-30-12 Fiscal Year: 6-30-12

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

	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	27,242	474	1,440	29,156		29,156		29,156			1
2	Food Purchase		58,472		58,472		58,472		58,472			2
3	Housekeeping	2,445	3,406		5,851		5,851		5,851			3
4	Laundry		1,577		1,577		1,577		1,577			4
5	Heat and Other Utilities			1,147	1,147		1,147	9,685	10,832			5
6	Maintenance	14,936	305	5,264	20,505		20,505	28,462	48,967			6
7	Other (specify):*	7,991	690		8,681		8,681		8,681			7
8	TOTAL General Services	52,614	64,924	7,851	125,389		125,389	38,147	163,536			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	14,205	8,705	6,000	28,910		28,910		28,910			10
10a	Therapy			1,705	1,705		1,705		1,705			10a
11	Activities		1,028		1,028		1,028		1,028			11
12	Social Services	3,975			3,975		3,975		3,975			12
13	CNA Training											13
14	Program Transportation		3,665	1,328	4,993		4,993		4,993			14
15	Other (specify):*	225,631			225,631		225,631		225,631			15
16	TOTAL Health Care and Programs	243,811	13,398	12,633	269,842		269,842		269,842			16
	C. General Administration											
17	Administrative	11,166			11,166		11,166	26,302	37,468			17
18	Directors Fees											18
19	Professional Services			7,599	7,599		7,599		7,599			19
20	Dues, Fees, Subscriptions & Promotions			2,087	2,087		2,087	(8)	2,079			20
21	Clerical & General Office Expenses	63,567	4,276		67,843		67,843		67,843			21
22	Employee Benefits & Payroll Taxes			91,189	91,189		91,189	(830)	90,359			22
23	Inservice Training & Education			1,086	1,086		1,086		1,086			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,177	1,177		1,177	8,543	9,720			26
27	Other (specify):*											27
28	TOTAL General Administration	74,733	4,276	103,138	182,147		182,147	34,007	216,154			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	371,158	82,598	123,622	577,378		577,378	72,154	649,532			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			1,367	1,367		1,367	34,789	36,156			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,017	1,017		1,017	51,513	52,530			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			53,444	53,444		53,444		53,444			34
35	Rent-Equipment & Vehicles			5,674	5,674		5,674		5,674			35
36	Other (specify):*											36
37	TOTAL Ownership			61,502	61,502		61,502	86,302	147,804			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			35,062	35,062		35,062		35,062			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,062	35,062		35,062		35,062			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	371,158	82,598	220,186	673,942		673,942	158,456	832,398			45

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

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(830)	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	(8)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (838)		\$	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	159,294	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 159,294		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 158,456		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:

7-1-11

Ending:

6-30-12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Allowable Depreciation from Relate Party PLH	\$ 34,342	30	1
2	Allowable Interest from Related Party PLH	51,513	32	2
3	Allowable Related Party Depreciation PLA	447	30	3
4	Allowable Related Party Utilities	9,685	5	4
5	Allowable Related Party Maintenance	28,462	6	5
6	Allowable Related Party Administrative	26,302	17	6
7	Allowable Related Party Insurance	8,543	26	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	159,294		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Home # 0035527 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	9,685	0	0	0	0	0	0	0	0	0	0	9,685	5
6	Maintenance	28,462	0	0	0	0	0	0	0	0	0	0	28,462	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	38,147	0	0	0	0	0	0	0	0	0	0	38,147	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	26,302	0	0	0	0	0	0	0	0	0	0	26,302	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	(8)	0	0	0	0	0	0	0	0	0	0	(8)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(830)	0	0	0	0	0	0	0	0	0	0	(830)	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	8,543	0	0	0	0	0	0	0	0	0	0	8,543	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	34,007	0	0	0	0	0	0	0	0	0	0	34,007	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	72,154	0	0	0	0	0	0	0	0	0	0	72,154	29

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-11 Ending: 6-30-12 Summary B

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	34,789	0	0	0	0	0	0	0	0	0	0	34,789	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	51,513	0	0	0	0	0	0	0	0	0	0	51,513	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	86,302	0	0	0	0	0	0	0	0	0	0	86,302	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)	158,456	0	0	0	0	0	0	0	0	0	0	158,456	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
				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 page 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	Bill Downs	BOD						7
8	Marilyn Wnuk	BOD						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 Home # 0035527 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 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	Not Applicable						\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	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

[illegible]

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 Home

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0035527

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.	Exempt	\$	\$
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:	5,524	B. General Construction Type:	Exterior	Concrete	Frame	Aluminum Gutter, dov	Number of Stories	1
------------------------	--------------	--------------------------------------	-----------------	-----------------	--------------	-----------------------------	--------------------------	----------

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	\$	\$ 555,758
5										
6										
7										
8										
	Improvement Type**									
9	Garage		1995	18,306	732	25	732			12,509
10	Door East Side		2001	950	63	15	63			697
11	Bathroom Floor Tile		2001	625	42	15	42			483
12	Vinyl Flooring		2002	15,657	1,566	10	1,566			15,657
13	Storm Sewer		2002	37,480	378	10	378			3,780
14	4 Thermostats		2007	1,965	98	20	98			532
15	Sidewalks, Handrail, & Door		2007	7,815	391	20	391			1,986
16	8 Toilets		2009	3,573	179	20	179			551
17	Galv Frames Shower		2009	1,833	91	20	91			275
18	Door Hardware		2009	3,370	168	20	168			518
19	Door Hardware Installation		2009	1,140	57	20	57			176
20	Wall Corner Guards		2009	1,050	70	15	70			204
21	Washroom Wall & Floor Tile		2009	6,880	459	15	459			1,300
22	Additional Door Hardware		2009	732	37	20	37			105
23	4 Vapor Proof lights Bath Area		2010	1,075	108	10	108			261
24	Fence Repair		2010	1,260	126	10	126			242
25	Roof		2011	16,805	747	15	747			747
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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)		\$ 797,491	\$ 32,391		\$ 32,391	\$	\$ 595,781	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	\$ 19,920	\$ 1,502	\$ 1,502	\$	various	\$ 8,829	71
72	Current Year Purchases	5,777	449	449		various	449	72
73	Fully Depreciated Assets	27,957					27,957	73
74								74
75	TOTALS	\$ 53,654	\$ 1,951	\$ 1,951	\$		\$ 37,235	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			\$ 20,391	\$ 1,814	\$ 1,814	\$	5	\$ 2,559	76
77										77
78										78
79										79
80	TOTALS			\$ 20,391	\$ 1,814	\$ 1,814	\$		\$ 2,559	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)	\$ 948,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,156	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,156	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)	\$ 635,575	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? ☐ YES ☒ NO
- If NO, see instructions.

		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: \$ 4,511 Description: PACE \$1,822, Copier \$2,689
- (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.		\$ 64.46	\$ 773	17
18					18
19					19
20					20
21	TOTAL		\$ 64.46	\$ 773	21

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	\$
13.	06/30/2014	\$
14.	06/30/2015	\$

* 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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(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 Operating	2 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 Operating	2 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	\$ 594,926	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 594,926	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	1,750	10	
11 CNA Training Reimbursements	3,624	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)	\$ 5,374	23	
D. Non-Operating Revenue			
24 Contributions	74,683	24	
25 Interest and Other Investment Income***		25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 74,683	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)	\$ 674,983	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	125,389	31	
32 Health Care	269,842	32	
33 General Administration	182,147	33	
B. Capital Expense			
34 Ownership	61,502	34	
C. Ancillary Expense			
35 Special Cost Centers		35	
36 Provider Participation Fee	35,062	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 673,942	40	
41 Income before Income Taxes (line 30 minus line 40)**	1,041	41	
42 Income Taxes	1,041	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
2	Assistant Director of Nursing					2
3	Registered Nurses	574	581	14,205	24.45	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	126	131	3,975	30.34	11
12	Dietician					12
13	Food Service Supervisor	308	393	6,149	15.65	13
14	Head Cook	1,825	2,030	21,093	10.39	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	894	1,033	14,936	14.46	17
18	Housekeepers	283	296	2,445	8.26	18
19	Laundry					19
20	Administrator	136	225	11,166	49.63	20
21	Assistant Administrator					21
22	Other Administrative	796	922	22,628	24.54	22
23	Office Manager	1,607	2,068	38,485	18.61	23
24	Clerical	171	186	2,454	13.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	177	184	2,849	15.48	28
29	Resident Services Coordinator	579	682	23,306	34.17	29
30	Habilitation Aides (DD Homes)	14,932	15,669	165,467	10.56	30
31	Medical Records					31
32	Other Health Care(specify)	37	38	3,148	82.84	32
33	Other(specify)	2,556	3,060	38,852	12.70	33
34	TOTAL (lines 1 - 33)	25,001	27,498	\$ 371,158 *	\$ 13.50	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	\$ 1,440	1-3	35
36	Medical Director	29	3,600	9-3	36
37	Medical Records Consultant				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	31	1,705	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)	156	\$ 12,745		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	%	Amount	Description		Amount	Description	Amount	
James R. Weise	Executive Director	0	\$ 8,848	Workers' Compensation Insurance		\$ 6,633	IDPH License Fee	\$	
Julie Ground	Deputy Ex. Dir.	0	2,318	Unemployment Compensation Insurance		5,453	Advertising: Employee Recruitment	150	
				FICA Taxes		29,047	Health Care Worker Background Check		
				Employee Health Insurance		48,088	(Indicate # of checks performed <u>7</u>)	72	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Membership Dues	1,437	
				Employer Match		1,138	License Fees Other	121	
				Man Ben \$830 not included in total			Subscriptions & Texts	299	
TOTAL (agree to Schedule V, line 17, col. 1)							Public Relations	8	
(List each licensed administrator separately.)			\$ 11,166						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 90,359		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
James Himmel	Legal		\$ 5			\$	Out-of-State Travel	\$	
Cocalas Westberg Mommsen	Audit		846						
Kronos	Comptert P/R		1,232						
ADP	Comptert P/R		1,004				In-State Travel		
Community Services Partners	Data Processing		3,268						
Peter Ptak	Data Processing		91						
Sage Software	Data Processing Software		117						
Wessels Sherman	Legal H-R		58				Seminar Expense		
Concast	Internet		978						
							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.)			\$ 7,599				TOTAL		

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount.

No

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
various

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 638 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 35,062

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Indicate the amount. \$ 0

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

Yes
\$ 0

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

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

N/A

	Related Party Adjustment						Park Lawn Home	
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

D. Vehicle Depreciation

1	2		3	4	Current	%	5	6	Program %	7	8
Use	Make, Model & Year		Year	Cost	Book		Program	Straight	Straight	Adjustments	Life in
			Acquired		Depreciation		% Depre.	Line Depr.	Line Dep.		Years
Activities	98 Econo Van	**	2005	\$7,333.50	\$0.00	6.42	\$0.00	\$0.00	\$0.00		5
Activities	05 Ford Free	**	2006	\$17,632.33	\$0.00	6.42	\$0.00	\$0.00	\$0.00		5
Activities	96 Merucry Sable	**	1996	\$19,929.00	\$0.00	6.42	\$0.00	\$0.00	\$0.00		5
Activities	11 Ford E350	**	2011	\$34,833.00	\$6,966.70	6.42	\$447.26	\$6,966.70	\$447.26		5
Activities	03 Ford Eldorado	*	2003	\$54,404.53	\$0.00	5.01	\$0.00	\$0.00	\$0.00		5
Activities	08 Chervrolet Braun	*	2007	\$32,564.00	\$6,512.80	5.01	\$326.29	\$6,512.80	\$326.29		5
Activities	08 Eldorado Aerotech	*	2008	\$52,873.00	\$10,574.60	5.01	\$529.79	\$10,574.60	\$529.79		5
Activities	09 Ford Eldorado Aerotech	*	2010	\$57,819.00	\$11,563.80	5.01	\$579.35	\$11,563.80	\$340.55		5
Activities	11 Ford E450 SuperDuty	*	2010	\$57,746.00	\$5,774.60	5.01	\$289.31	\$5,774.60	\$170.06		5
				\$335,134.36	\$41,392.50		\$2,171.99	\$41,392.50	\$1,813.95		

* Owned by Park Lawn School Depreciation \$1,366.69

** Owned by Park Lawn Association Depreciation \$447.26
1813.95

	Program	Cost	Total Program	Program	Accumulated	Total
	Percentag		Cost	Percentag	Depreciation	Program
	e			e		Accum
						Depreciati
						on
* Owned by Park Lawn School Depreciation	0.0642	\$255,406.53	\$16,397.10	0.0642	\$34,425.80	\$2,210.14
** Owned by Park Lawn Association Depreciation	0.0501	<u>\$79,727.83</u>	<u>\$3,994.36</u>	0.0501	<u>\$6,966.70</u>	<u>\$349.03</u>
		\$335,134.36	\$20,391.46		\$41,392.50	\$2,559.17

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 5.01% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

9

Accumulated
Depreciation

\$7,333.50
\$17,632.33
\$19,929.00
\$10,450.00
\$54,404.53
\$29,850.33
\$44,060.83
\$28,427.68
\$11,549.20
\$223,637.40

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	0.0642	\$18.94	\$227.27
	Activities		98 Econo Van	\$61.00	0.0642	\$3.92	\$46.99
	Activities		96 Mercury Sable	\$67.00	0.0642	\$4.30	\$51.62
	Activities		11 Ford E350	\$581.00	0.0642	\$37.30	\$447.60
21	Totals			\$1,004.00		\$64.46	\$773.48

Explanation Notes:

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

Line 15 Column 1		
Staff Trainer	\$3,104	
QMRP	\$2,849	
Psych	\$3,148	
Resident Services Coor	\$23,306	
Facility Services Coor	\$27,757	
Hab Aides	<u>\$165,467</u>	
	\$225,631	

Schedule V. Page 3 & 4		
Line 5 Column 7	Allowable Related Party Costs for Utilities	\$9,685
Line 6 Column 7	Allowable Related Party Costs for Maintenance	\$28,462
Line 17 Column 7	Allowable Related Party Costs for Administrative	\$26,302
Line 26 Column 7	Allowable Related Party Costs for Insurance	\$8,543
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	\$34,342
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLA	\$447
Line 32 Column 7	Allowable Related Party Costs for Interest PLH	<u>\$51,513</u>
		\$159,294

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	\$43,763
Equipment from Park Lawn Association	<u>\$1,655</u>
	\$53,444

Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	\$773
Equipment Rental	\$3,079
Pace Vehicle Rental	<u>\$1,822</u>
	\$5,674

Schedule VII. Part B Page 6		
Park Lawn Association, Inc.		
Depreciation of Vehicles		\$447

Total Park Lawn Association Costs

Park Lawn Homes, Inc.		
Utilities	\$9,685	
Maintenance	\$28,462	
Administration	\$26,302	
Taxes/Insurance	\$8,543	
Interest	\$51,513	
Depreciation Bldg. & Equipment	<u>\$34,342</u> *	
Total Park Lawn Homes Costs		<u>\$158,847</u>

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

Total Related Party Adjustment on Page 5A Line 49	\$159,294
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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/Bkkp - % of Budget
- 3. P/R Personnel - % of Staff

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 5.01% usage are wheel chair accessible and must be used to transport wheelchair count 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 5.01% 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.