

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 S Kostner Ave Alsip 60803
Number City Zip Code

County: Cook

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

HFS ID Number:

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

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

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: Tom Ryan Telephone Number: 708-634-0513
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 7/1/2024 to 6/30/2025 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) 10-29-2025
(Type or Print Name) Tom Ryan
(Title) 708-925-7882

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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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	15	Intermediate/DD	15	5,475	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	4,311							4,311	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,311							4,311	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 78.74%

D. How many bed reserve days during this year were paid by the Department? 365 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) _____

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/22/1982

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 certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

* 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	44,518	1,258	1,839	47,615		47,615		47,615			1
2	Food Purchase		52,926		52,926		52,926		52,926			2
3	Housekeeping	3,846	3,376		7,222		7,222		7,222			3
4	Laundry		2,166		2,166		2,166		2,166			4
5	Heat and Other Utilities			1,263	1,263		1,263	12,818	14,081			5
6	Maintenance	22,104	435	4,285	26,824		26,824	41,615	68,439			6
7	Other (specify):*		3,269		3,269		3,269		3,269			7
8	TOTAL General Services	70,468	63,430	7,387	141,285		141,285	54,433	195,718			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	40,899	6,426	5,795	53,120		53,120		53,120			10
10a	Therapy			5,492	5,492		5,492		5,492			10a
11	Activities	44,976	1,448		46,424		46,424		46,424			11
12	Social Services	8,921			8,921		8,921		8,921			12
13	CNA Training											13
14	Program Transportation		6,884	1,928	8,812		8,812		8,812			14
15	Other (specify):*	390,935		18,808	409,743		409,743		409,743			15
16	TOTAL Health Care and Programs	485,731	14,758	32,023	532,512		532,512		532,512			16
	C. General Administration											
17	Administrative	174,029			174,029		174,029	54,447	228,476			17
18	Directors Fees											18
19	Professional Services			12,997	12,997		12,997		12,997			19
20	Dues, Fees, Subscriptions & Promotions			4,072	4,072		4,072	(2,406)	1,666			20
21	Clerical & General Office Expenses		3,794		3,794		3,794		3,794			21
22	Employee Benefits & Payroll Taxes			152,314	152,314		152,314		152,314			22
23	Inservice Training & Education			2,182	2,182		2,182		2,182			23
24	Travel and Seminar			1,544	1,544		1,544		1,544			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			847	847		847	14,459	15,306			26
27	Other (specify):*											27
28	TOTAL General Administration	174,029	3,794	173,956	351,779		351,779	66,500	418,279			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	730,228	81,982	213,366	1,025,576		1,025,576	120,933	1,146,509			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			1,059	1,059		1,059	13,220	14,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							33,405	33,405			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			57,554	57,554		57,554		57,554			34
35	Rent-Equipment & Vehicles			1,143	1,143		1,143		1,143			35
36	Other (specify):*											36
37	TOTAL Ownership			59,756	59,756		59,756	46,625	106,381			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			53,800	53,800		53,800		53,800			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			53,800	53,800		53,800		53,800			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	730,228	81,982	326,922	1,139,132		1,139,132	167,558	1,306,690			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				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				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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	167,558	5-A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 167,558		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 167,558		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (2,406)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7	Allowable Related Party Utilities	12,818	5	7
8	Allowable Related Party Maintenance	41,615	6	8
9	Allowable Related Party Administration	54,447	17	9
10	Allowable Related Party Insurance	14,459	26	10
11	Allowable Related Party Depreciation	13,220	30	11
12	Allowable Related Party Interest	33,405	32	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	167,558		49

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Park Lawn Assn	Oak Lawn	Supp. Org.
				Park Lawn Homes	Alsip	Supp. Org.

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 pg 5A in notes		\$	\$	1
2	V								2
3	V				Park Lawn Homes, See explanation on pg 5A 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 (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
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								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: 7/1/2024 Ending: 5/30/2025

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 23				\$	\$		\$	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.)

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

FACILITY NAME	Park Lawn Home	COUNTY	Cook
---------------	----------------	--------	------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,524 B. General Construction Type: Exterior Brick Frame Aluminum Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (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).

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. 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.

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

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			1999	\$ 676,975	\$	25	\$	\$	676,975
5										
6										
7										
8										
	Improvement Type**									
9	Garage		1995		18,306					18,306
10	Door East Side		2001		950					950
11	Bathroom Floor Tile		2001		625					625
12	Vinyl Flooring		2002		15,657					15,657
13	Storm Sewer		2002		3,780					3,780
14	4 Thermostats		2007		1,965	98		98		1,806
15	Sidewalks, Handrail, & Door		2007		7,815	390		390		7,063
16	8 Toilets		2009		3,573	179		179		2,878
17	Galv Frames Shower		2009		1,833	92		92		1,465
18	Door Hardware		2009		3,370	168		168		2,702
19	Door Hardware Installation		2009		1,140	57		57		914
20	Wall Corner Guards		2009		1,050	6		6		1,050
21	Washroom Wall & Floor Tile		2009		6,880	73		73		6,880
22	Additional Door Hardware		2009		732	36		36		578
23	4 Vapor Proof lights Bath Area		2010		1,075					1,075
24	Fence Repair		2010		1,260					1,260
25	Roof		2011		16,805	1,120		1,120		15,308
26	HVAC 4 Units		2012		34,035	2,269		2,269		28,552
27	Paint in copier room		2014		975					975
28	Drywall in Copier Room		2014		650	33		33		364
29	Framing for Copier Room		2014		450	23		23		253
30	Door to Copier Room		2014		700	35		35		388
31	Permits & License		2014		365	18		18		201
32	Painting Kitchen & Dining Area		2014		2,150	108		108		1,186
33	Flooring in Kitchen & Dining Area		2014		4,275	214		214		2,353
34	Electrical in Kitchen & Dining Area		2014		2,157	108		108		1,198
35	Plumbing in Kitchen		2014		1,565	78		78		860
36	Counter Tops in Kitchen		2014		2,250	113		113		1,241

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	Cabinets in Kitchen	2014	\$ 3,890	\$ 195	20	\$ 195	\$	\$ 1,946	37
38	Hutch Unit in Dining Area	2014	3,250	163	20	163		1,626	38
39	Preparation & Demolition in Kitchen & Dining Areas	2014	6,495	325	20	325		3,249	39
40	Repave and Strip Parking Lot	2014	33,342	1,667	20	1,667		15,559	40
41	Vinyl Flooring - Men's Side	2016	16,558	1,656	10	1,656		10,350	41
42	Mixing Valves	2017	1,049		5			1,049	42
43	Check Valve	2017	4,935		5			4,935	43
44	Generator - Gas Meter & Fuel Line	2018	2,665	178	15	178		1,068	44
45	Generator - Boring for Gas Pipe	2019	2,270	151	15	151		906	45
46	Generator - Concrete Pad for Generator	2019	3,440	229	15	229		1,374	46
47	Generator - Permits	2019	742	49	15	49		294	47
48	Generator - Equipment	2019	32,769	2,185	15	2,185		13,110	48
49	Generator - Balance	2020	13,494	900	15	900		5,400	49
50	Building Tuckpointing	2021	950	63	15	63		305	50
51	Vinyl Flooring - Women's Side	2022	16,584	1,106	15	1,106		3,410	51
52	Sealing/Restriping Parking Lot	2023	1,950	195	10	195		455	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)		\$ 957,746	\$ 14,279		\$ 14,279	\$	\$ 861,878	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,034,788	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,279	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,279	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)	\$ 861,878	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 1,143 Description: Copier 1070, Pace 73
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

12345678										
	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	\$ 2,050,530	\$	1
2	Cash-Patient Deposits	116,396		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			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,166,926	\$	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	909,027		15
16	Equipment, at Historical Cost	(640,752)		16
17	Accumulated Depreciation (book methods)			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)	\$ 268,275	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,435,201	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,826,923	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	116,396		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	689,245		30
31	Accrued Taxes Payable (excluding real estate taxes)			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
36	Other Current Liabilities(specify):			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,632,564	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,632,564	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (197,360)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,435,204	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 81,594	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 81,594	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(278,954)	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)	\$ (278,954)	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)	\$ (197,360)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning: 7/1/2024

Ending:

6/30/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 843,330	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 843,330	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		10
11	CNA Training Reimbursements		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions	16,848	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,848	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)	\$ 860,178	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	141,285	31
32	Health Care	532,512	32
33	General Administration	351,779	33
	B. Capital Expense		
34	Ownership	59,756	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	53,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,139,132	40
41	Income before Income Taxes (line 30 minus line 40)**	(278,954)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (278,954)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	56

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	656	656	\$ 27,903	\$ 42.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses					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	2,088	2,309	44,976	19.48	10
11	Social Service Workers	248	248	8,921	35.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,157	2,375	44,518	18.74	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	862	862	22,103	25.64	17
18	Housekeepers	185	185	3,845	20.78	18
19	Laundry					19
20	Administrator	441	441	18,877	42.80	20
21	Assistant Administrator	2,189	2,332	94,771	40.64	21
22	Other Administrative	1,312	2,399	60,381	25.17	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	617	780	22,309	28.60	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,913	18,015	381,624	21.18	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	27,668	30,602	\$ 730,228 *	\$ 23.86	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	23	\$ 1,839	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	795	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	64	5,492	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiastrist</u>	24	5,000	10-3	46
47	<u>Behavioral</u>	249	18,808	15-3	47
48					48
49	TOTAL (lines 35 - 48)	371	\$ 31,934		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.

Facility Name & ID Number	Park Lawn Home
--------------------------------------	-----------------------

0035527

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	1,210
Other, please specify	
Collab Healthcare Urgency Group	456
	1,666 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	
Other: Clearbrook, UCP Seguin, Don Moss	2,336
Collab Healthcare Urgency Group	
Other, please specify CARF International	70
	2,406 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	1,210
Other: Clearbrook, UCP Seguin, Don Moss	2,336
Collab Healthcare Urgency Group	456
	70
	4,072 Total
- (5)

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

\$ 1,468 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 53,800

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ NO Has any meal income been offset against related costs? Indicate the amount. \$
- (12)

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?

NA, 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. \$
- (13)

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

YES

Firm Name: Adducci & Vega Financial Group
- (14)

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

YES
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

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

Schedule VIII. Part B

Central Office - 10833 S' LaPorte Ave occupies 1,717 square feet Administration and Accounting and Bookkeeping
This is 6.9% of total square footage of 24,693.
The Administrative salaries are distributed on the percentage of budget basis.