



Facility Name & ID Number Park Lawn Center

# 0027078 Report Period Beginning: 7-1-07 Ending: 6-30-08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	41	Intermediate/DD	41	15,006	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	15,006	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	13,972			13,972	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,972			13,972	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.11%

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

311 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 09/22/82

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

YES  Date 9/22/82 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

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-07 Ending: 6-30-08

**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
	<b>A. General Services</b>										
1	Dietary	128,988	1,168	5,040	135,196		135,196	135,196			1
2	Food Purchase		132,389		132,389		132,389	132,389			2
3	Housekeeping	30,395	9,669		40,064		40,064	40,064			3
4	Laundry	6,600	8,300		14,900		14,900	14,900			4
5	Heat and Other Utilities			69,686	69,686		69,686	69,686			5
6	Maintenance	39,907	40,126	12,119	92,152		92,152	92,152			6
7	Other (specify):* <a href="#">See Notes</a>		1,992		1,992		1,992	1,992			7
8	<b>TOTAL General Services</b>	<b>205,890</b>	<b>193,644</b>	<b>86,845</b>	<b>486,379</b>		<b>486,379</b>	<b>486,379</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400	8,400			9
10	Nursing and Medical Records	277,182	49,922	99,484	426,588		426,588	426,588			10
10a	Therapy			5,362	5,362		5,362	5,362			10a
11	Activities	18,906	682		19,588		19,588	19,588			11
12	Social Services	6,507			6,507		6,507	6,507			12
13	CNA Training										13
14	Program Transportation	18,823	7,188	3,448	29,459		29,459	29,459			14
15	Other (specify):* <a href="#">See Notes</a>	693,468		25	693,493		693,493	693,493			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,014,886</b>	<b>57,792</b>	<b>116,719</b>	<b>1,189,397</b>		<b>1,189,397</b>	<b>1,189,397</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	45,099			45,099		45,099	45,099			17
18	Directors Fees										18
19	Professional Services			35,525	35,525		35,525	35,525			19
20	Dues, Fees, Subscriptions & Promotions			31,079	31,079		31,079	(59)	31,020		20
21	Clerical & General Office Expenses	127,102	19,853		146,955		146,955		146,955		21
22	Employee Benefits & Payroll Taxes			286,648	286,648		286,648	(2,047)	284,601		22
23	Inservice Training & Education			2,434	2,434		2,434		2,434		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			24,646	24,646		24,646		24,646		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>172,201</b>	<b>19,853</b>	<b>380,332</b>	<b>572,386</b>		<b>572,386</b>	<b>(2,106)</b>	<b>570,280</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,392,977</b>	<b>271,289</b>	<b>583,896</b>	<b>2,248,162</b>		<b>2,248,162</b>	<b>(2,106)</b>	<b>2,246,056</b>		<b>29</b>

\*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.

Facility Name & ID Number Park Lawn Center

#0027078

Report Period Beginning:

7-1-07

Ending:

6-30-08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			3,669	3,669	(1,800)	1,869	150,325	152,194			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,141	1,141		1,141	147,751	148,892			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			131,048	131,048		131,048	(131,048)				34
35	Rent-Equipment & Vehicles			14,824	14,824		14,824	(4,487)	10,337			35
36	Other (specify):* <a href="#">See Notes</a>			4,487	4,487	1,800	6,287		6,287			36
37	<b>TOTAL Ownership</b>			155,169	155,169		155,169	162,541	317,710			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			132,897	132,897		132,897		132,897			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			132,897	132,897		132,897		132,897			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,392,977	271,289	871,962	2,536,228		2,536,228	160,435	2,696,663			45

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning: 7-1-07

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**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	(2,047)	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	(59)	20		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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,106)		\$	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	2	
		Amount	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)	162,541	5A	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 162,541		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 160,435		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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Park Lawn Center

ID# 0027078

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Allowable Depreciation from Related Party	\$ 150,325	30	1
2	Allowable Interest from Related Party	147,751	32	2
3	Rent - Facility & Grounds	(131,048)	34	3
4	Rent - Equipment & Vehicles	(4,487)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	162,541		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-07

Ending:

6-30-08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(59)	0	0	0	0	0	0	0	0	0	0	(59)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,047)	0	0	0	0	0	0	0	0	0	0	(2,047)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(2,106)	0	0	0	0	0	0	0	0	0	0	(2,106)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(2,106)	0	0	0	0	0	0	0	0	0	0	(2,106)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-07

Ending:

6-30-08

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	150,325	0	0	0	0	0	0	0	0	0	0	150,325	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	147,751	0	0	0	0	0	0	0	0	0	0	147,751	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(131,048)	0	0	0	0	0	0	0	0	0	0	(131,048)	34
35	Rent-Equipment & Vehicles	(4,487)	0	0	0	0	0	0	0	0	0	0	(4,487)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>162,541</b>	<b>0</b>	<b>162,541</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>160,435</b>	<b>0</b>	<b>160,435</b>	<b>45</b>									

Facility Name & ID Number Park Lawn Center

# 0027078

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**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 Organizati

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	Park Lawn Association, See Explanation on page 5A	N/A	\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

Park Lawn Center

#

0027078

Report Period Beginning:

7-1-07

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## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Not Applicable								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Park Lawn Center

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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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Founders Bank		X	Mortgage	interest	12-29-05	\$ 3,000,000	\$ 2,956,544	12-15-12	4.8750	\$ 147,704	1								
2	Ford Credit		X	Ford Freestyle	\$331.93	4-8-06	17,632	10,229	4-8-11	4.9000	47	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$331.93		\$ 3,017,632	\$ 2,966,773			\$ 147,751	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,017,632	\$ 2,966,773			\$ 147,751	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.)

Facility Name & ID Number Park Lawn Center# 0027078 Report Period Beginning: 7-1-07Ending: 6-30-08

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
<b>Not Applicable</b>				
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

## NOTES:

- Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
- 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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Park Lawn Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027078

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. _____	Not Applicab le	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocation:**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

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

Facility Name & ID Number Park Lawn Center

# 0027078 Report Period Beginning:

7-1-07 Ending:

6-30-08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 24,891 B. General Construction Type: Exterior Brick & Aluminium S Frame \_\_\_\_\_ Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

N/A

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

1. Total Amount Incurred: Completely Amortized 6-30-08 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facilities</u>	<u>124,955</u>	<u>1981</u>	<u>\$ 190,000</u>	1
2					2
3	<b>TOTALS</b>	<u>124,955</u>		<u>\$ 190,000</u>	3

Facility Name &amp; ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-07

Ending:

6-30-08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	41		1982		\$ 210,000	\$ 6,000	35	\$ 6,000	\$	\$ 1,545,636	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Plumbing, Heat & AC		1982	165,500	4,729	35	4,729		122,954	9
10		Electric & Fixtures		1982	81,400	2,326	35	2,326		60,476	10
11		Elevator		1982	33,385	954	35	954		24,804	11
12		Concrete		1982	43,171	1,233	35	1,233		16,262	12
13		Sprinklers		1982	22,085	631	35	631		16,386	13
14		Bath. Access.		1982	2,450	70	35	70		1,820	14
15		Construction Int		1982	18,357	525	35	525		13,650	15
16		Carpentry		1982	23,800	680	35	680		2,380	16
17		Windows		1982	33,088	945	35	945		24,573	17
18		Ceramic Tile		1982	10,621	303	35	303		7,878	18
19		Painting		1982	10,166	290	35	290		7,540	19
20		Various Construction Materials		1982	75,966	2,170	35	2,170		56,420	20
21		Permits		1982	1,803	52	35	52		1,352	21
22		Architect Fee		1982	29,577	844	35	844		21,944	22
23		Construction Manager		1982	40,000	1,143	35	1,143		29,718	23
24		Demolition		1982	6,858	196	35	196		5,096	24
25		Windows		1983	4,258	171	25	171		4,258	25
26		Sewer & Sump Pump		1983	4,933		10			4,933	26
27		Windows		1986	850	34	25	34		756	27
28		Generator		1986	15,785		20			15,785	28
29		Fence/Gate		1993	2,053		10			2,053	29
30		Roof Repair		1997	26,382	1,759	15	1,759		20,959	30
31		Tile Main area and Floor Patch		2001	5,857	586	10	586		3,954	31
32		Compressor		2004	2,475	165	15	165		660	32
33		4 stage Chiller		2005	1,285	85	15	85		334	33
34		Elevator Pump		2005	6,200	620	10	620		1,033	34
35		General Contractor Job Superintendent		2007	180,564	4,514	40	4,514		5,643	35
36		Fee		2007	210,949	5,274	40	5,274		6,592	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-07

Ending:

6-30-08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	<a href="#">Ins. &amp; Permits</a>	2007	\$ 184,211	\$ 4,605	40	\$ 4,605	\$	\$ 5,757	37
38	<a href="#">Estimate Contingency</a>	2007	1,471	37	40	37		46	38
39	<a href="#">Roofing</a>	2007	185,247	4,631	40	4,631		5,789	39
40	<a href="#">Metal Wall Panels</a>	2007	17,760	444	40	444		555	40
41	<a href="#">Sun Screens</a>	2007	46,408	1,160	40	1,160		1,450	41
42	<a href="#">HVAC</a>	2007	230,756	5,769	40	5,769		7,211	42
43	<a href="#">Electrical</a>	2007	366,412	9,160	40	9,160		11,450	43
44	<a href="#">Final Cleaning</a>	2007	1,145	29	40	29		36	44
45	<a href="#">Selective Demolition</a>	2007	39,425	986	40	986		1,232	45
46	<a href="#">Earthwork</a>	2007	103,726	2,593	40	2,593		3,241	46
47	<a href="#">Asphalt Paving</a>	2007	56,525	1,413	40	1,413		1,766	47
48	<a href="#">Fencing</a>	2007	12,113	303	40	303		379	48
49	<a href="#">Landscaping</a>	2007	23,679	592	40	592		740	49
50	<a href="#">Concrete</a>	2007	148,644	3,716	40	3,716		4,645	50
51	<a href="#">Steel</a>	2007	18,829	471	40	471		588	51
52	<a href="#">Carpentry</a>	2007	592,248	14,806	40	14,806		18,508	52
53	<a href="#">Millwork</a>	2007	35,126	878	40	878		1,098	53
54	<a href="#">Drywall &amp; Acoustical</a>	2007	233,229	5,831	40	5,831		7,288	54
55	<a href="#">Calking</a>	2007	4,232	106	40	106		132	55
56	<a href="#">Doors &amp; Hardware</a>	2007	77,373	1,934	40	1,934		2,418	56
57	<a href="#">R/R Coiling Doors</a>	2007	3,148	79	40	79		98	57
58	<a href="#">Overhead Doors</a>	2007	3,450	86	40	86		108	58
59	<a href="#">Aluminum Entrances</a>	2007	67,203	1,680	40	1,680		2,100	59
60	<a href="#">Wood Windows</a>	2007	82,549	2,064	40	2,064		2,580	60
61	<a href="#">Tile &amp; Carpet</a>	2007	126,869	3,172	40	3,172		3,965	61
62	<a href="#">Painting</a>	2007	47,690	1,192	40	1,192		1,490	62
63	<a href="#">Toilet Acc/Floor Mat/Fire Ext/Tack Baord</a>	2007	15,955	399	40	399		399	63
64	<a href="#">Acrovyn Wall Protection</a>	2007	20,486	512	40	512		640	64
65	<a href="#">Fire Protection</a>	2007	112,086	2,802	40	2,802		3,503	65
66	<a href="#">Plumbing</a>	2007	387,850	9,696	40	9,696		12,120	66
67	<a href="#">Low Voltage</a>	2007	20,482	512	40	512		640	67
68	<a href="#">Fire Hydrant</a>	2007	9,975	249	40	249		312	68
69	<a href="#">Two Monument Signs</a>	2007	4,750	119	40	119		148	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 4,550,870	\$ 118,325		\$ 118,325	\$	\$ 2,128,281	70

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

Facility Name &amp; ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-07

Ending:

6-30-08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,550,870	\$ 118,325		\$ 118,325	\$	\$ 2,128,281	1
2	<u>Metal Studs</u>	2007	13,225	331	40	331		413	2
3	<u>Architect</u>	2007	348,281	8,707	40	8,707		10,884	3
4	<u>Legal</u>	2007	4,095	102	40	102		128	4
5	<u>Soil Boring</u>	2007	1,200	30	40	30		38	5
6	<u>Survey</u>	2007	2,300	58	40	58		72	6
7	<u>Phone system</u>	2007	12,262	307	40	307		383	7
8	<u>Title Company Fees</u>	2007	5,410	135	40	135		169	8
9	<u>General Contractor Job Superintendent</u>	2007	22,050	276	40	276		276	9
10	<u>General Contractor Fees</u>	2007	71,712	896	40	896		896	10
11	<u>Roofing</u>	2008	53,578	670	40	670		570	11
12	<u>Sun Screens</u>	2008	27,467	343	40	343		343	12
13	<u>HVAC</u>	2008	42,548	506	40	506		506	13
14	<u>Electrical</u>	2008	42,114	526	40	526		526	14
15	<u>Selective Demolition</u>	2008	2,018	25	40	25		25	15
16	<u>Earthwork</u>	2008	5,459	68	40	68		68	16
17	<u>Asphalt Paving</u>	2008	2,975	37	40	37		37	17
18	<u>Fencing</u>	2008	638	8	40	8		8	18
19	<u>Landscaping</u>	2008	8,958	155	40	155		155	19
20	<u>Concrete</u>	2008	7,823	98	40	98		98	20
21	<u>Steel</u>	2008	3,641	46	40	46		46	21
22	<u>Carpentry</u>	2008	31,944	399	40	399		399	22
23	<u>Millwork</u>	2008	11,554	144	40	144		144	23
24	<u>Drywall &amp; Acoustical</u>	2008	54,781	685	40	685		685	24
25	<u>Doors &amp; Hardware</u>	2008	5,007	62	40	62		62	25
26	<u>Aluminum Entrances</u>	2008	8,517	106	40	106		106	26
27	<u>Wood Windows</u>	2008	1,395	17	40	17		17	27
28	<u>Tile &amp; Carpet</u>	2008	12,794	160	40	160		160	28
29	<u>Painting</u>	2008	23,111	466	40	466		466	29
30	<u>Toilet Acc/Floor Mat/ Fire Ext/Tack Board</u>	2008	2,465	31	40	31		31	30
31	<u>Acrovyn Wall Protection</u>	2008	472	6	40	6		6	31
32	<u>Fire Protection</u>	2008	37,852	473	40	473		473	32
33	<u>Plumbing</u>	2008	41,841	581	40	581		581	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,460,357	\$ 134,779		\$ 134,779	\$	\$ 2,147,052	34

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-07

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6-30-08

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,460,357	\$ 134,779		\$ 134,779	\$	\$ 2,147,052	1
2	Low Voltage	2008	23,516	318	40	318		318	2
3	Fire Hydrant	2008	525	7	40	7		7	3
4	Two Monument Signs	2008	12,250	273	40	273		273	4
5	Metal Studs	2008	4,295	107	40	107		107	5
6	Architect	2008	1,969	25	40	25		25	6
7	Phone System	2008	10,053	126	40	126		126	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	TOTAL (lines 1 thru 33)		\$ 5,512,965	\$ 135,635		\$ 135,635	\$	\$ 2,147,908	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-07 Ending: 6-30-08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 109,283	\$ 9,011	\$ 9,011		various	\$ 22,828	71
72	Current Year Purchases	69,478	5,126	5,126		5,10,20	5,126	72
73	Fully Depreciated Assets	153,056				various	153,056	73
74								74
75	TOTALS	\$ 331,817	\$ 14,137	\$ 14,137	\$		\$ 181,010	75

D. Vehicle Depreciation (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 on page 25.		various	\$ 24,191	\$ 2,422	\$ 2,422		5	\$ 15,275	76
77										77
78										78
79										79
80	TOTALS			\$ 24,191	\$ 2,422	\$ 2,422	\$		\$ 15,275	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,058,973	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,194	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 152,194	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)	\$ 2,344,193	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	<b>TOTAL</b>				\$			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: \$ 10,337 Description: Copiers \$7,096, PACE \$3,177, Pagers \$64

(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	<u>See attached listing page 26</u>		\$ <u>264.35</u>	\$ <u>3,172</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>264.35</u>	\$ <u>3,172</u>	21

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. \_\_\_\_\_ \$ \_\_\_\_\_

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* 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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>90 OJT</u></p>
--	---	--

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>19</b>

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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 prescripts													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.

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning: 7-1-07

Ending:

6-30-08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 222,980	\$	1
2	Cash-Patient Deposits	77,511		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	4,274		5
6	Prepaid Insurance	49,254		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	908,926		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,262,945	\$	10
<b>B. Long-Term Assets</b>				
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	444,747		16
17	Accumulated Depreciation (book methods)	(349,450)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 95,297	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,358,242	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 95,568	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	77,372		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	447,816		30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,426)		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
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 618,330	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Equipment &amp; Leases</u>	630,431		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 630,431	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,248,761	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 109,481	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,358,242	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 109,369	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 109,369	6
<b>A. Additions (deductions):</b>			
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) <b>Net income other department</b>	112	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 112</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 109,481</b>	<b>24</b> *

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

Facility Name & ID Number Park Lawn Center# 0027078Report Period Beginning: 7-1-07

Ending:

6-30-08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,269,004	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,269,004	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	28,077	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 28,077	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	248,959	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 248,959	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,546,040	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	486,379	31
32	Health Care	1,189,397	32
33	General Administration	572,386	33
<b>B. Capital Expense</b>			
34	Ownership	155,169	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	132,897	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,536,228	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	9,812	41
42	<b>Income Taxes</b>	9,812	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Notes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-07

Ending:

6-30-08

**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	625	687	\$ 23,394	\$ 34.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,883	3,602	93,352	25.92	3
4	Licensed Practical Nurses	3,794	4,221	99,710	23.62	4
5	CNAs & Orderlies	4,860	5,720	60,726	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,522	1,800	18,906	10.50	10
11	Social Service Workers	237	246	6,507	26.45	11
12	Dietician					12
13	Food Service Supervisor	1,402	1,664	25,305	15.21	13
14	Head Cook	839	886	7,377	8.33	14
15	Cook Helpers/Assistants	10,282	11,058	96,306	8.71	15
16	Dishwashers					16
17	Maintenance Workers	2,335	2,816	39,907	14.17	17
18	Housekeepers	3,239	3,566	30,395	8.52	18
19	Laundry	805	836	6,600	7.89	19
20	Administrator	804	1,011	45,099	44.61	20
21	Assistant Administrator					21
22	Other Administrative	3,443	4,235	81,830	19.32	22
23	Office Manager	1,932	2,328	45,272	19.45	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,136	5,680	87,374	15.38	28
29	Resident Services Coordinator	666	700	24,558	35.08	29
30	Habilitation Aides (DD Homes)	50,850	56,237	545,594	9.70	30
31	Medical Records					31
32	Other Health Care(specify)	94	94	7,650	81.38	32
33	Other(specify)	3,678	4,164	47,115	11.31	33
34	TOTAL (lines 1 - 33)	99,426	111,551	\$ 1,392,977 *	\$ 12.49	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	252	\$ 5,040	1-3	35
36	Medical Director	56	8,400	9-3	36
37	Medical Records Consultant	18	630	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	480	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	98	5,363	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	34	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	\$ 25,913		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,343	\$ 79,802	10-3	50
51	Licensed Practical Nurses	338	12,572	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,681	\$ 92,374		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
James Weise	Executive Director	0	\$ 27,323	Workers' Compensation Insurance	\$ 51,196	IDPH License Fee	\$ 27,818	
Julia Grounds	Deputy Executive Dir.	0	17,776	Unemployment Compensation Insurance	16,796	Advertising: Employee Recruitment	27,818	
				FICA Taxes	102,965	Health Care Worker Background Check	1,107	
				Employee Health Insurance	110,039	(Indicate # of checks performed 105 )		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		Membership dues	1,665	
				Employer match TSA	3,605	Subscriptions & Texts	188	
				Man. Ben \$2,047 not included in total		Public Relations	59	
						License Fee Other	242	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 45,099					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				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		\$ 15				Out-of-State Travel	\$
Vanden Beck LLC	Legal		14					
Cocalas, Westberg & Mommsen	Audit		3,023					
ADP	Payroll		12,559				In-State Travel	
Intregation Works	Data Processing		4,513					
Foley & Lardner LLP	Legal		15,349					
Wessels & Pautsch	Human Resource Advice		52				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 35,525			\$	Entertainment Expense	( )
							(agree to Sch. V,	
							line 24, col. 8)	
							TOTAL	\$

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? various
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,360 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 132,927  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 0 Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A Personal use not permitted.  
g. Does the facility transport residents to and from day training? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Cocalas, Westberg, & Mommsen, Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.



1 Use	2 Make, Model & Year	3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Prog. % of Depreciation	6 Straight Line Depreciation	Program % of Straight Line Depr.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation
Medical Appts.	96 Mercury Sable	**	1996	19929	0	0	0	0		5	19929
Medical Appts.	97 Ford Club Wagon	**	1997	\$27,413.00	\$0.00	\$0.00	\$0.00	\$0.00		5	\$27,413.00
Medical Appts.	2005 Free Ford	**	2006	\$17,632.00	\$3,526.27	12.1	\$426.68	\$3,526.47	\$426.68	5	\$8,228.43
Medical Appts.	05 Ford Tarus	**	2007	\$10,922.00	\$2,184.46	12.1	\$264.32	\$1,456.31	\$264.32	-	\$3,640.77
Medical Appts.	01 Light Duty Ford Eldorac	*	2002	\$44,353.00	\$2,956.87	8	\$236.55	\$2,956.87	\$236.55	-	\$44,353.00
Medical Appts.	02 Mini Van Chevy Ventur	*	2002	\$33,545.00	\$2,236.33	8	\$178.91	\$2,236.33	\$178.91		\$33,545.00
Medical Appts.	03 Ford Eldorado	*	2003	\$54,404.53	\$10,880.91	8	\$870.47	\$10,881.00	\$870.47		\$48,057.33
Medical Appts.	2008 Chevy Braun	*	2007	\$32,564.00	\$3,799.13	8	\$303.93	\$3,799.13	\$303.93		\$3,799.13
Medical Appts.	2008 Eldorado Aerotech	*	2008	\$52,873.00	\$1,762.43	8	\$140.99	\$1,762.43	\$140.99		\$1,762.43
				\$273,706.53	\$27,346.40		\$2,421.85	\$26,618.54	\$2,421.85		\$170,799.09
			*								
			**								\$131,516.89
	* Owned by Park Lawn School			Depreciation	\$1,730.85						\$10,521.35
	** Owned by Park Lawn Assoc.			Depreciation	\$691.00						
					\$2,421.85						

Due to the number of Participants transported in all Park Lawn Programs, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis. The vehicles with 8% usage are almost all wheel chair accessible and must be used when transporting wheel chair bound participants.

	Program %	Cost	Program Cost	Program %	Accum. Deprec	Program Accum Deprec.
Owned by Park Lawn School	0.08	\$217,739.53	\$17,419.16	0.08	\$131,516.89	\$10,521.35
Owned by Park Lawn Assoc.	0.121	\$55,967.00	\$6,772.01	0.121	\$39,282.20	\$4,753.15
			\$24,191.17			
					\$15,274.50	

XII. C. Vehicle Rental

1 Use	2 Make, Model & Year	3 Monthly Lease Pymt.	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
Activities	2005 Free Ford	\$325.00	0.12	39.00	\$468.00
Activities	2005 Ford Taurus	\$325.00	0.12	39.00	\$468.00
Activities	96 Mercury Sable Station Wagon	\$175.00	0.38	66.62	\$799.47
Activities	97 Ford Club Wagon	\$315.00	0.38	119.73	\$1,436.78
21 Totals		\$1,140.00		264.35	\$3,172.25



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

Line 7 Column 2			
Pest Control	\$1,111		
Plant Security	<u>\$881</u>		
	\$1,992		
Line 15 Column 1			
QMRP	\$87,374		
Res. Serv. Coord.	\$24,558		
Hab. Aides	\$545,594		
Facility Service Aide	\$25,420		
Staff Trainer	\$2,872		
Psychiatrist	<u>\$7,650</u>		
	\$693,468		
Line 23 Column 8			
American Red Cross	CPR Class materials	\$443.98	
The Stay Well Co	First Aid Class materials	\$26.50	
AID Training Dept.	Seminar	\$67.37	
Central Illinois DD Nursing	Conference	\$100.00	
Illinois Council on Long Term Care	Conference	\$118.37	
I.C.A.N. Inc.	Conference	\$82.68	
Cross County Education	Dementia Convention	\$95.67	
Paula Kluth	Speaker for In-Service	\$107.35	
Pathfinder	Seminars	\$165.61	
Chicago Kent College of Law	NonProfit Conference	\$54.60	
The Arc of Illinois	Leadership Conference	\$550.74	
SHRM Convention	HR Conference	\$322.44	
Safeway	Refreshments	<u>\$298.69</u>	
		\$2,434.00	

Schedule V, Page 4  
 Line 30 Column 5 To move depreciation of \$1,800 on assets acquired with Capital Acquisition Grant from DMH which is unallowed so it won't be included in depreciation number that we need to tie to.

Line 36 Column 2 Loss on Disposition of Assets \$4487.

Line 36 Column 5 Unallowed Capital Acquisition Grant Depreciation identified

Line 30 Column 7 Related Party Allowable Depreciation, Public Aid Depreciation is less than Book Depreciation.			
Building Depreciation	\$135,573.00		
Vehicle Depreciation	\$691.00		
Equipment Depreciation	<u>\$14,061.00</u>		
		\$150,325.00	

Line 35 Column 8 Community Leased equipment: Pagers \$62, Copier \$5,121, PACE \$3,177

Schedule VII, Part B			
Park Lawn Association, Inc.			
Building Rental not allowed			(\$131,048)
Equipment Rental not allowed			(\$4,487)
Allowable Building Interest	\$147,704		
Allowable Vehicle Interest \$592 X 8%	<u>\$47</u>		
		\$147,751	
Depreciation Allowed			
Building	\$135,573		
Vehicle Depreciation	\$691		
Equipment	<u>\$14,061</u>		
Total Depreciation Allowed *		<u>\$150,325</u>	
* Based on Public Aid allowable Depreciation Book Depreciation on building is \$2,400 higher than Public Aid allowable depreciation			
Total Related Party Adjustment Detailed on Page 5A line 49			\$162,541.00

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

Schedule IX Interest Expense	Column 10		
Hinsdale Bank & Ford Credit	This programs share of vehicle interest \$592 X 8%	\$47.00	
Founders Bank	This programs mortgage interest allowed from related party	\$147,704.00	

Schedule XI. Part D

Line 46 Column 5 Includes only the program portion of depreciation costs on vehicles.

Due to the number of Participants transported in all Park Lawn Programs, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.

The vehicles with 8% usage are almost all wheel chair accessible and must be used when transporting wheel chair bound participants.

Schedule XII Part C Page 14

Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis. These vehicle lease costs are only program portion and are for activities.

A detailed schedule of proration is on Page 26.

Schedule XIII. B Page 15

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

Schedule XVIII. Page 19

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

Schedule XVIII. Page 20 Line 33

Drivers	\$18,823
Facilities Service	\$25,420
Trainer	\$2,872
	<hr/>
	\$47,115

Schedule XX. Page 23

Question 12 Allocated on basis of hours worked per department

Question 15 No Employee meals are served