



Facility Name & ID Number Park Lawn Center

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

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	14,282			14,282	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,282			14,282	14

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

D. How many bed-hold days during this year were paid by the Department? 252 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? 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 09/22/82 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: 6-30-12 Fiscal Year: 6-30-12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	142,217	4,485	7,410	154,112		154,112	154,112			1
2	Food Purchase		193,324		193,324		193,324	193,324			2
3	Housekeeping	49,982	9,503		59,485		59,485	59,485			3
4	Laundry	31,930	10,607		42,537		42,537	42,537			4
5	Heat and Other Utilities			59,941	59,941		59,941	59,941			5
6	Maintenance	14,695	25,941	29,398	70,034		70,034	70,034			6
7	Other (specify):*	21,084	3,630		24,714		24,714	24,714			7
8	<b>TOTAL General Services</b>	259,908	247,490	96,749	604,147		604,147	604,147			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400	8,400			9
10	Nursing and Medical Records	306,613	65,592	24,875	397,080		397,080	397,080			10
10a	Therapy			7,315	7,315		7,315	7,315			10a
11	Activities	35,144	621		35,765		35,765	35,765			11
12	Social Services	11,714			11,714		11,714	11,714			12
13	CNA Training										13
14	Program Transportation		8,539	3,629	12,168		12,168	12,168			14
15	Other (specify):*	799,210			799,210		799,210	799,210			15
16	<b>TOTAL Health Care and Programs</b>	1,152,681	74,752	44,219	1,271,652		1,271,652	1,271,652			16
	<b>C. General Administration</b>										
17	Administrative	34,641			34,641		34,641	34,641			17
18	Directors Fees										18
19	Professional Services			27,699	27,699		27,699	27,699			19
20	Dues, Fees, Subscriptions & Promotions			4,980	4,980		4,980	(135)	4,845		20
21	Clerical & General Office Expenses	126,262	24,854		151,116		151,116	151,116			21
22	Employee Benefits & Payroll Taxes			345,316	345,316		345,316	(2,813)	342,503		22
23	Inservice Training & Education			3,258	3,258		3,258		3,258		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			20,548	20,548		20,548		20,548		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	160,903	24,854	401,801	587,558		587,558	(2,948)	584,610		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,573,492	347,096	542,769	2,463,357		2,463,357	(2,948)	2,460,409		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Park Lawn Center

#0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

## 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			4,937	4,937	(1,269)	3,668	169,939	173,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,180	2,180		2,180	138,138	140,318			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			131,048	131,048		131,048	(131,048)				34
35	Rent-Equipment & Vehicles			17,527	17,527		17,527	(5,904)	11,623			35
36	Other (specify):* <b>Unallowed Depreciation</b>					1,269	1,269		1,269			36
37	<b>TOTAL Ownership</b>			155,692	155,692		155,692	171,125	326,817			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			141,893	141,893		141,893		141,893			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			141,893	141,893		141,893		141,893			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,573,492	347,096	840,354	2,760,942		2,760,942	168,177	2,929,119			45

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning: 7-1-11

Ending: 6-30-12

**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	(2,813)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(135)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,948)		\$	30

BHF USE ONLY					
48		49		50	51
					52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	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)			34
35	Other- Attach Schedule	171,125	5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 171,125		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 168,177		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Park Lawn Center

ID# 0027078

Report Period Beginning: 7-1-11

Ending: 6-30-12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Allowable Depreciation from Related Party	\$ 169,939	30	1
2	Allowable Interest from Related Party	138,138	32	2
3	Rent-Facility & Grounds	(131,048)	34	3
4	Rent-Equipment & Vehicles	(5,904)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		171,125	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</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>8</b>
	<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>	<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>16</b>
	<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	(135)	0	0	0	0	0	0	0	0	0	0	(135)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,813)	0	0	0	0	0	0	0	0	0	0	(2,813)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(2,948)</b>	<b>0</b>	<b>(2,948)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(2,948)</b>	<b>0</b>	<b>(2,948)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	169,939	0	0	0	0	0	0	0	0	0	0	169,939	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	138,138	0	0	0	0	0	0	0	0	0	0	138,138	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(131,048)	0	0	0	0	0	0	0	0	0	0	(131,048)	34
35	Rent-Equipment & Vehicles	(5,904)	0	0	0	0	0	0	0	0	0	0	(5,904)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>171,125</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>171,125</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	168,177	0	0	0	0	0	0	0	0	0	0	168,177	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Park Lawn Assoc.	Oak Lawn	Support Organizatio

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		\$	\$	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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number

Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jonathan Perry	BOD						1
2	Steve Janiszewski	BOD						2
3	Robert Schwartzers	BOD						3
4	Bonnie Price	BOD						4
5	Bill Downs	BOD						5
6	James Himmel	BOD						6
7	Marilyn Wnuk	BOD						7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

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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	<a href="#">See page 27.</a>				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

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	Name of Lender	2		3	4	5	6		8	9	10						
		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>																
	Long-Term																
1	Private Bank		X	Mortgage	interest	12-29-05	\$ 3,000,000	\$ 2,758,207	12-15-12	4.8750	\$ 138,138	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 3,000,000	\$ 2,758,207			\$ 138,138	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>						\$ 3,000,000	\$ 2,758,207			\$ 138,138	15					

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2011 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <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:	2007 _____	8	<b>FOR BHF USE ONLY</b>			
	2008 _____	9				
	2009 _____	10				
	2010 _____	11				
	2011 _____	12				
<b>Not Applicable</b>			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
			14	PLUS APPEAL COST FROM LINE 5	\$	14
			15	LESS REFUND FROM LINE 6	\$	15
			16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027078

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

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

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

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

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

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Park Lawn Center

# 0027078 Report Period Beginning:

7-1-11 Ending:

6-30-12

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

N/A

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

1. Total Amount Incurred: Completely Amortized 6-30-08 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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:

7-1-11

Ending:

6-30-12

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	41	1982		\$ 210,000	\$ 6,000	35	\$ 6,000	\$	\$ 178,636	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		141,870	9
10	Electric & Fixtures	1982		81,400	2,326	35	2,326		69,780	10
11	Elevator	1982		33,385	954	35	954		28,620	11
12	Concrete	1982		43,171	1,233	35	1,233		21,194	12
13	Sprinklers	1982		22,085	631	35	631		18,910	13
14	Bath. Access.	1982		2,450	70	35	70		2,100	14
15	Construction Int	1982		18,357	525	35	525		15,750	15
16	Carpentry	1982		23,800	680	35	680		20,400	16
17	Windows	1982		33,088	945	35	945		28,353	17
18	Ceramic Tile	1982		10,621	303	35	303		9,090	18
19	Painting	1982		10,166	290	35	290		8,700	19
20	Various Construction Materials	1982		75,966	2,170	35	2,170		65,100	20
21	Permits	1982		1,803	52	35	52		1,560	21
22	Architect Fee	1982		29,577	844	35	844		25,320	22
23	Construction Manager	1982		40,000	1,143	35	1,143		34,290	23
24	Demolition	1982		6,858	196	35	196		5,880	24
25	Windows	1983		4,258		25			4,258	25
26	Sewer & Sump Pump	1983		4,933		10			4,933	26
27	Windows	1986		850		25			850	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	146	15	146		26,382	30
31	Tile Main area and Floor Patch	2001		5,857	145	10	145		5,857	31
32	Compressor	2004		2,475	165	15	165		1,320	32
33	4 Stage Chiller	2005		1,285	85	15	85		674	33
34	Elevator Pump	2005		6,200	620	10	620		3,513	34
35	General Contractor Job Superintendent	2007		180,564	4,514	40	4,514		185,078	35
36	General Contractor Fees	2007		210,949	5,274	40	5,274		27,688	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

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

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

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

Facility Name &amp; ID Number Park Lawn Center

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

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

Facility Name & ID Number Park Lawn Center

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

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 298,426	\$ 24,115	\$ 24,115	\$	various	\$ 152,476	71
72	Current Year Purchases	11,698	814	814		various	814	72
73	Fully Depreciated Assets	141,866					141,866	73
74								74
75	TOTALS	\$ 451,990	\$ 24,929	\$ 24,929	\$		\$ 295,156	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See page 25.			\$ 38,590	\$ 4,305	\$ 4,305	\$	5	\$ 26,510	76
77										77
78										78
79										79
80	TOTALS			\$ 38,590	\$ 4,305	\$ 4,305	\$		\$ 26,510	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,261,469	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,607	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,607	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,830,197	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending: 6-30-12

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning 7-1-11

Ending 6-30-12

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 06/30/2013 \$ 125,592

13. 06/30/2014 \$ 125,592

14. 06/30/2015 \$ 125,592

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 11,607 Description: PACE \$4857, Copier \$6750

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See attached listing page 26</u>		\$ <u>375.96</u>	\$ <u>4,512</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>375.96</u>	\$ <u>4,512</u>	21

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

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

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

<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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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**

<b>COMPLETED</b>	
1. From this facility	8
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	8

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	<b>TOTAL</b>			\$		\$	\$									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.**

Facility Name & ID Number **Park Lawn Center**

# **0027078**

Report Period Beginning: **7-1-11**

Ending:

**6-30-12**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **6-30-12** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 97,828	\$	1
2	Cash-Patient Deposits	87,743		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,777		6
7	Other Prepaid Expenses	13,042		7
8	Accounts Receivable (owners or related parties)	1,259,710		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,502,100</b>	<b>\$</b>	<b>10</b>
<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	542,376		16
17	Accumulated Depreciation (book methods)	(398,120)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 144,256</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 1,646,356</b>	<b>\$</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 164,955	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	87,705		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	373,198		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,967		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 636,825</b>	<b>\$</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	893,288		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 893,288</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,530,113</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 116,243</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 1,646,356</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 116,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 116,243	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)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$	17
<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>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 116,243	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,380,379	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,380,379	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	4,667	10
11	CNA Training Reimbursements	15,442	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 20,109	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	363,983	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 363,983	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>	\$ 2,764,471	30

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

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

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

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

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

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-11

Ending:

6-30-12

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

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

\* 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	72	\$ 7,410	1-3	35
36	Medical Director	29	8,400	9-3	36
37	Medical Records Consultant	10	350	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	133	7,315	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	24	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	268	\$ 29,475		49

**C. CONTRACT NURSES**

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

**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 R. Weise	Executive Director	0	\$ 30,037	Workers' Compensation Insurance	\$ 33,620	IDPH License Fee	\$	
Julie Grounds	Deputy Ex. Dir.	0	4,604	Unemployment Compensation Insurance	27,646	Advertising: Employee Recruitment	603	
				FICA Taxes	121,397	Health Care Worker Background Check	593	
				Employee Health Insurance	154,773	(Indicate # of checks performed <u>59</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Membership Dues	3,163	
				Employer Match	5,067	License Fees Other	231	
				Man Ben \$2813 not included in total		Subscriptions & Texts	255	
						Public Relations	135	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 34,641			Less: Public Relations Expense	(135)	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 342,503	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,845	
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		\$ 17			\$	Out-of-State Travel	\$
Cocalas Westberg & Mommsen	Audit		2,870					
Kronos	Computer P/R		6,211					
ADP	Computer P/R		5,860				In-State Travel	
Community Services Partners	Data Processing		10,879					
Peter Ptak	Data Processing		403					
Sage Software	Data Processing Software		396					
Wessels Sherman	Legal H-R		196				Seminar Expense	
Comcast	Internet		867					0
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 27,699	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$

\* Attach copy of IMRF notifications

\*\*See instructions.

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

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

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? various
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,990 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 141,893  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 0 Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A Personal use not permitted  
**g. Does the facility transport residents to and from day training? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Cocalas, Westberg, & Mommsen, LTD.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.

Related Party Adjustment

Park Lawn Center

Lease Adjustment  
Management Benefits  
P/R & In Kind

ADJUSTMENT EXPLANATION  
2011/2012 FY

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

584,272.41



9

Accumulated  
Depreciation

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

XII. C. Vehicle Rental

1 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	\$285.00	0.241	68.69	\$824.22
Activities	2005 Ford Taurus	\$285.00	0.241	68.69	\$824.22
Activities	96 Mercury Sable Station Wagon	\$200.00	0.241	48.20	\$578.40
Activities	1998 Econo Van	\$200.00	0.241	48.20	\$578.40
Activities	2011 Ford E 350	\$590.00	0.241	142.19	\$1,706.28
21 Totals		\$1,560.00		375.96	\$4,511.52



Explanation Notes:

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

Line 7 Column 2

Cable TV	774
Pest Control	\$1,574
Plant Security	<u>\$1,282</u>
	\$3,630

Line 15 Column 1

Staff Trainer	\$10,535
QMRP	\$113,580
Res. Serv. Coord.	\$27,760
Hab. Aides	\$638,840
Psychiatrist	<u>\$8,495</u>
	\$799,210

Schedule V. Page 4

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

Line 36 Column 5 Unallowed Capital Acquisition Grant Depreciation identified

Line 30 Column 7 Related Party Allowable Depreciation, Public Aid Depreciation is less than Book Depreciation.

Building Depreciation	\$146,411	
Vehicle Depreciation	\$700.00	
Equipment Depreciation	<u>\$22,828.00</u>	
		\$169,939.00

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

Schedule VII. Part B

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



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	Hrs. Worked Hrs. Paid & Accrued		
Drivers	1993	2129	\$21,084
Trainer	488	576	\$10,535
	<u>2481</u>	<u>2705</u>	<u>\$31,619</u>

Schedule XX. Page 23

Question 15 No Employee meals are served