

Facility Name & ID Number Park Lawn Center

0027078 Report Period Beginning: 7-1-12 Ending: 6-30-13

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	14,965	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	14,965	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	14,193			14,193
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	14,193			14,193

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.84%

D. How many bed-hold days during this year were paid by the Department? 319 (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)

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: 6-30-13 Fiscal Year: 6-30-13

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,965	4,407	7,380	150,752		150,752	150,752		1	
2	Food Purchase		160,740		160,740		160,740	160,740		2	
3	Housekeeping	53,611	10,560		64,171		64,171	64,171		3	
4	Laundry	38,679	12,065		50,744		50,744	50,744		4	
5	Heat and Other Utilities			61,952	61,952		61,952	61,952		5	
6	Maintenance	7,425	25,258	27,343	60,026		60,026	60,026		6	
7	Other (specify):* Cable, Pest, Security,	24,289	3,546		27,835		27,835	27,835		7	
8	TOTAL General Services	262,969	216,576	96,675	576,220		576,220	576,220		8	
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400	8,400		9	
10	Nursing and Medical Records	312,999	71,767	9,239	394,005		394,005	394,005		10	
10a	Therapy			8,250	8,250		8,250	8,250		10a	
11	Activities	39,572	249		39,821		39,821	39,821		11	
12	Social Services	13,572			13,572		13,572	13,572		12	
13	CNA Training									13	
14	Program Transportation		9,058	3,864	12,922		12,922	12,922		14	
15	Other (specify):* See page 27 notes	821,572			821,572		821,572	821,572		15	
16	TOTAL Health Care and Programs	1,187,715	81,074	29,753	1,298,542		1,298,542	1,298,542		16	
	C. General Administration										
17	Administrative	29,411			29,411		29,411	29,411		17	
18	Directors Fees									18	
19	Professional Services			25,495	25,495		25,495	25,495		19	
20	Dues, Fees, Subscriptions & Promotions			8,110	8,110		8,110	(45)	8,065	20	
21	Clerical & General Office Expenses	126,935	27,128		154,063		154,063		154,063	21	
22	Employee Benefits & Payroll Taxes			348,741	348,741		348,741	(2,552)	346,189	22	
23	Inservice Training & Education			5,900	5,900		5,900		5,900	23	
24	Travel and Seminar			486	486		486		486	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			19,345	19,345		19,345		19,345	26	
27	Other (specify):*									27	
28	TOTAL General Administration	156,346	27,128	408,077	591,551		591,551	(2,597)	588,954	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,607,030	324,778	534,505	2,466,313		2,466,313	(2,597)	2,463,716	29	

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	D. Ownership											
30	Depreciation			4,974	4,974	(1,269)	3,705	170,075	173,780			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,636	2,636		2,636	101,786	104,422			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			131,041	131,041		131,041	(131,041)				34
35	Rent-Equipment & Vehicles			16,576	16,576		16,576	(1,586)	14,990			35
36	Other (specify):* Unallowed Depreciation					1,269	1,269		1,269			36
37	TOTAL Ownership			155,227	155,227		155,227	139,234	294,461			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,824	142,824		142,824		142,824			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			142,824	142,824		142,824		142,824			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,607,030	324,778	832,556	2,764,364		2,764,364	136,637	2,901,001			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: 7-1-12

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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	(2,552)	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	(45)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,597)		\$	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	139,234	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 139,234		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 136,637		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	TOTAL (C): (sum of lines 38-46)			\$		47

Park Lawn Center

ID# 0027078

Report Period Beginning: 7-1-12

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Allowable Depreciation from Related Party	\$ 170,075	30	1
2	Allowable Interest from Related Party	101,786	32	2
3	Rent-Facility & Grounds	(131,041)	34	3
4	Rent-Equipment & Vehicles	(1,586)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	139,234		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center# 0027078

Report Period Beginning:

7-1-12

Ending:

6-30-13

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(45)	0	0	0	0	0	0	0	0	0	0	(45)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,552)	0	0	0	0	0	0	0	0	0	0	(2,552)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,597)	0	0	0	0	0	0	0	0	0	0	(2,597)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,597)	0	0	0	0	0	0	0	0	0	0	(2,597)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-12

Ending:

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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	170,075	0	0	0	0	0	0	0	0	0	0	170,075	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	101,786	0	0	0	0	0	0	0	0	0	0	101,786	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(131,041)	0	0	0	0	0	0	0	0	0	0	(131,041)	34
35	Rent-Equipment & Vehicles	(1,586)	0	0	0	0	0	0	0	0	0	0	(1,586)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	139,234	0	139,234	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	136,637	0	0	0	0	0	0	0	0	0	0	136,637	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
				Parl :awn 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	Total		\$			\$	\$ *	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:

7-1-12

Ending:

6-30-13

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	Jnathan 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

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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 27				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Park Lawn Center

0027078

Report Period Beginning:

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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			
A. Directly Facility Related																	
Long-Term																	
1	Private Bank		X	Mortgage	interest	12-15-12	\$ 3,000,000	\$ 2,693,971	1-1-18	2.9250	\$ 101,786						
2																	
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 3,000,000	\$ 2,693,971			\$ 101,786						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 2,693,971			\$ 101,786						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 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 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008 _____	8	FOR BHF USE ONLY			
	2009 _____	9				
	2010 _____	10			13 FROM R. E. TAX STATEMENT FOR 2012 \$	13
	2011 _____	11			14 PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	12			15 LESS REFUND FROM LINE 6 \$	15
Not Applicable			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.

2012 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 2012 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 2012.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

7-1-12 Ending:

6-30-13

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	TOTALS	124,955		\$ 190,000	3

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-12

Ending:

6-30-13

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			1982	\$ 210,000	\$ 6,000	35	\$ 6,000	\$	\$ 184,636	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Plumbing, Heat & AC		1982	165,500	4,729	35	4,729		146,599	9
10	Electric & Fixtures		1982	81,400	2,326	35	2,326		72,106	10
11	Elevator		1982	33,385	954	35	954		29,574	11
12	Concrete		1982	43,171	1,233	35	1,233		22,427	12
13	Sprinklers		1982	22,085	631	35	631		19,547	13
14	Bath. Access.		1982	2,450	70	35	70		2,170	14
15	Construction Int		1982	18,357	525	35	525		16,275	15
16	Carpentry		1982	23,800	680	35	680		21,080	16
17	Windows		1982	33,088	945	35	945		29,298	17
18	Ceramic Tile		1982	10,621	303	35	303		9,393	18
19	Painting		1982	10,166	290	35	290		8,990	19
20	Various Construction Materials		1982	75,966	2,170	35	2,170		67,270	20
21	Permits		1982	1,803	52	35	52		1,612	21
22	Architect Fee		1982	29,577	844	35	844		26,164	22
23	Construction Manager		1982	40,000	1,143	35	1,143		35,433	23
24	Demolition		1982	6,858	196	35	196		6,076	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		15			26,382	30
31	Tile Main area and Floor Patch		2001	5,857		10			5,757	31
32	Compressor		2004	2,475	165	15	165		1,485	32
33	4 Stage Chiller		2005	1,285	85	15	85		759	33
34	Elevator Pump		2005	6,200	620	10	620		4,133	34
35	General Contractor Job Superintendent		2007	180,564	4,514	40	4,514		28,213	35
36	General Contractor Fees		2007	210,949	5,274	40	5,274		32,962	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 & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-12

Ending:

6-30-13

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	\$	\$ 28,782	37
38	Estimate Contingency	2007	1,471	37	40	37		231	38
39	Roofing	2007	185,247	4,631	40	4,631		28,944	39
40	Metal Wall Panels	2007	17,760	444	40	444		2,775	40
41	Sun Screens	2007	46,408	1,160	40	1,160		7,250	41
42	HVAC	2007	230,756	5,769	40	5,769		36,056	42
43	Electrial	2007	366,412	9,160	40	9,160		57,250	43
44	Final Cleaning	2007	1,145	29	40	29		181	44
45	Selective Demolition	2007	39,425	986	40	986		6,162	45
46	Earthwork	2007	103,726	2,593	40	2,593		16,206	46
47	Asphalt Paving	2007	56,525	1,413	40	1,413		8,828	47
48	Fencing	2007	12,113	303	40	303		1,894	48
49	Landscapomg	2007	23,679	592	40	592		3,700	49
50	Concrete	2007	148,644	3,716	40	3,716		23,225	50
51	Steel	2007	18,829	471	40	471		2,943	51
52	Carpentry	2007	592,248	14,806	40	14,806		93,597	52
53	Millwork	2007	35,126	878	40	878		5,488	53
54	Drywall & acoustical	2007	233,229	5,831	40	5,831		36,443	54
55	Calking	2007	4,232	106	40	106		662	55
56	Door & Hardware	2007	77,373	1,934	40	1,934		12,088	56
57	R/R Coiling Doors	2007	3,148	79	40	79		493	57
58	Overhead Doors	2007	3,450	86	40	86		538	58
59	Aluminum Entrances	2007	67,203	1,680	40	1,680		10,500	59
60	Wood Windows	2007	82,549	2,064	40	2,064		12,900	60
61	Tile & Carpet	2007	126,869	3,172	40	3,172		19,825	61
62	Painting	2007	47,690	1,192	40	1,192		7,450	62
63	Toilet Acc/Floor Mat/ Fire Ext/ Tack board	2007	15,955	399	40	399		2,394	63
64	Aceovyn Wall Protection	2007	20,486	512	40	512		3,200	64
65	Fire Protection	2007	112,086	2,802	40	2,802		17,513	65
66	Plumbing	2007	387,850	9,696	40	9,696		60,600	66
67	Low Voltage	2007	20,482	512	40	512		3,200	67
68	Fire Hydrant	2007	9,975	249	40	249		1,557	68
69	Two Monument Signs	2007	4,750	119	40	119		743	69
70	TOTAL (lines 4 thru 69)		\$ 4,550,870	\$ 115,775		\$ 115,775	\$	\$ 1,339,838	70

**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	Totals from Page 12A, Carried Forward		\$ 4,550,870	\$ 115,775		\$ 115,775	\$	\$ 1,339,838	1
2	Metal Studs	2007	13,225	331	40	331		2,068	2
3	Architect	2007	348,281	8,707	40	8,707		54,419	3
4	Legal	2007	4,095	102	40	102		638	4
5	Soil Boring	2007	1,200	30	40	30		188	5
6	Survey	2007	2,300	58	40	58		362	6
7	Phone System	2007	12,262	307	40	307		1,918	7
8	Title Company Fees	2007	5,410	135	40	135		844	8
9	General Contractor Job Superintendent	2007	22,050	551	40	551		3,031	9
10	General Contractor Fees	2007	71,712	1,793	40	1,793		9,861	10
11	Roofing	2008	53,578	1,339	40	1,339		7,265	11
12	Sun Screens	2008	27,467	687	40	687		3,778	12
13	HVAC	2008	42,548	1,064	40	1,064		5,826	13
14	Electrical	2008	42,114	1,053	40	1,053		5,791	14
15	Selective Demolition	2008	2,018	50	40	50		275	15
16	Earthwork	2008	5,459	136	40	136		748	16
17	Asphalt Paving	2008	2,975	74	40	74		407	17
18	Fencing	2008	638	16	40	16		88	18
19	Landscaping	2008	8,958	224	40	224		1,275	19
20	Concrete	2008	7,823	196	40	196		1,078	20
21	Steel	2008	3,641	91	40	91		501	21
22	Carpntry	2008	31,944	799	40	799		4,394	22
23	Millwork	2008	11,554	289	40	289		1,589	23
24	Drywall & Acoustical	2008	54,781	1,370	40	1,370		7,535	24
25	Doors & Hardware	2008	5,007	125	40	125		687	25
26	Aluminum Entrances	2008	8,517	213	40	213		1,171	26
27	Wood Windows	2008	1,395	35	40	35		192	27
28	Tile & Carpet	2008	12,794	320	40	320		1,760	28
29	Painting	2008	23,111	578	40	578		3,353	29
30	Toilet Acc/Floor/Mat/Fire Ext/ Tack Board	2008	2,465	62	40	62		347	30
31	Acrovyn Wall Protection	2008	472	12	40	12		66	31
32	Fire Protection	2008	37,852	946	40	946		5,203	32
33	Plumbing	2008	41,841	1,043	40	1,043		5,799	33
34	TOTAL (lines 1 thru 33)		\$ 5,460,357	\$ 138,511		\$ 138,511	\$	\$ 1,472,295	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	Totals from Page 12B, Carried Forward		\$ 5,460,357	\$ 138,511		\$ 138,511	\$	\$ 1,472,295	1
2	Low Voltage	2008	23,516	588	40	588		2,352	2
3	Fire Hydrant	2008	525	13	40	13		52	3
4	Two Monument Signs	2008	12,250	306	40	306		1,224	4
5	Metal Studs	2008	4,295	107	40	107		428	5
6	Architect	2008	1,969	49	40	49		196	6
7	Phone System	2008	10,053	251	40	251		1,004	7
8	Aquarium	2009	7,827	783	10	783		3,132	8
9	Artwork	2009	1,510	151	10	151		604	9
10	Dedication Sign	2009	2,553	54	40	54		216	10
11	Two Electric Heaters	2009	1,121	28	40	28		112	11
12	Vinyl Tile Front Entrance	2009	1,468	37	40	37		148	12
13	Wallcovering & Chair Rail	2009	3,992	100	40	100		400	13
14	Masonry Restoration	2009	3,685	184	20	184		736	14
15	Tuckpointing Bldg.	2010	9,800	490	20	490		1,797	15
16	Parking Lot Lighting	2010	3,480	174	20	174		595	16
17	Pump Work	2010	1,522	101	15	101		345	17
18	Two Marley Heaters	2010	2,618	261	10	261		1,092	18
19	Door Hardware	2010	1,488	74	20	74		222	19
20	Crack filling/sealcoating of lot	2010	4,747	475	10	475		1,385	20
21	Exhaust Fan add on Elevator Room	2011	2,775	278	10	278		624	21
22	Canopy Sprinkler Installation	2011	9,290	619	15	619		1,290	22
23	Completion of River Rock to CR Drive	2011	1,097	110	10	110		220	23
24	Redo Center Landscaping	2011	5,869	261	15	261		552	24
25	Water Heater	2012	3,082	77	10	77		385	25
26	Sprinkler Pipe Chases	2013	4,172	35	20	35		35	26
27	Modifications to Fire Sprinkler Piping	2013	12,150	203	20	203		203	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,597,211	\$ 144,320		\$ 144,320	\$	\$ 1,491,644	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 257,087	\$ 23,647	\$ 23,647	\$	various	\$ 123,086	71
72	Current Year Purchases	30,122	1,390	1,390		various	1,390	72
73	Fully Depreciated Assets	194,903				various	194,903	73
74								74
75	TOTALS	\$ 482,112	\$ 25,037	\$ 25,037	\$		\$ 319,379	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			\$ 40,677	\$ 4,423	\$ 4,423	\$		\$ 32,266	76
77										77
78										78
79										79
80	TOTALS			\$ 40,677	\$ 4,423	\$ 4,423	\$		\$ 32,266	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)	\$ 6,310,000	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,780	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,780	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)	\$ 1,843,289	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:

7-1-12

Ending: 6-30-13

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 7-1-12

Ending 6-30-13

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

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

12. 06/30/2014 \$ 125,592

13. 06/30/2015 \$ 125,592

14. 06/30/2016 \$ 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: \$ 14,990 Description: PACE \$5,010 and Copier \$6,527

(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>287.75</u>	\$ <u>3,453</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>287.75</u>	\$ <u>3,453</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.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-12 Ending: 6-30-13
 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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	Not Applicable	hrs	\$		\$		\$									1
2	Licensed Speech and Language Development Therapist		hrs														2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist		hrs														4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy		# of prescrpts														9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify):																13
14	TOTAL			\$		\$		\$			\$		\$				14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

0027078

Report Period Beginning: **7-1-12**

Ending:

6-30-13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6-30-13** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 55,596	\$	1
2	Cash-Patient Deposits	96,964		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	49,283		6
7	Other Prepaid Expenses	25,725		7
8	Accounts Receivable (owners or related parties)	1,689,821		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,917,389	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	542,376		16
17	Accumulated Depreciation (book methods)	(447,327)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 95,049	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,012,438	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 148,040	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	96,879		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	388,947		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 633,866	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,262,329		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,262,329	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,896,195	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 116,243	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,012,438	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 116,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 116,243	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 116,243	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,280,389	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,280,389	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	16,308	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,308	23
D. Non-Operating Revenue			
24	Contributions	473,284	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 473,284	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,769,981	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	576,220	31
32	Health Care	1,298,542	32
33	General Administration	591,551	33
B. Capital Expense			
34	Ownership	155,229	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	142,824	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,764,366	40
41	Income before Income Taxes (line 30 minus line 40)**	5,615	41
42	Income Taxes	5,615	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,939,930	44
45	Private Pay - Net Inpatient Revenue	340,459	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,280,389	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:

7-1-12

Ending:

6-30-13

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	1,788	2,032	\$ 61,918	\$ 30.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,112	4,328	118,136	27.30	3
4	Licensed Practical Nurses	4,766	5,287	132,945	25.15	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	3,175	3,596	39,572	11.00	10
11	Social Service Workers	422	449	13,572	30.23	11
12	Dietician					12
13	Food Service Supervisor	1,712	1,832	28,826	15.73	13
14	Head Cook	2,259	2,486	27,476	11.05	14
15	Cook Helpers/Assistants	7,541	7,755	82,663	10.66	15
16	Dishwashers					16
17	Maintenance Workers	370	428	7,425	17.35	17
18	Housekeepers	4,790	5,242	53,611	10.23	18
19	Laundry	2,513	2,707	38,679	14.29	19
20	Administrator	441	541	29,411	54.36	20
21	Assistant Administrator					21
22	Other Administrative	2,702	3,691	78,519	21.27	22
23	Office Manager	1,748	2,080	39,724	19.10	23
24	Clerical	479	665	8,692	13.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,815	8,661	130,446	15.06	28
29	Resident Services Coordinator	651	770	28,253	36.69	29
30	Habilitation Aides (DD Homes)	52,480	57,026	641,537	11.25	30
31	Medical Records					31
32	Other Health C: <u>Psychologist</u>	115	115	9,384	81.60	32
33	Other(specify) <u>Drivers/Trainer</u>	2,769	3,057	36,043	11.79	33
34	TOTAL (lines 1 - 33)	102,648	112,748	\$ 1,606,832 *	\$ 14.25	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	246	\$ 7,380	1-3	35
36	Medical Director	34	8,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	150	8,250	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	18	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	448	\$ 28,530		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	43	\$ 2,587	10-3	50
51	Licensed Practical Nurses	54	2,152	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	97	\$ 4,739		53

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning: 7-1-12

Ending: 6-30-13

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. \$ 27,037 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. \$ 142,824
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.

550,207.95

1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Prog. % of Depreciation	6 Straight Line Depreciation	Program % of Straight Line Depr.	7 Adjustments	8 Life in Years
Medical Appts.	96 Mercury Sable	**	1996	\$19,929.00	0	10.31	0	0	0		5
Medical Appts.	98 Econo Van	**	2004	\$7,333.50	\$0.00	10.31	\$0.00	\$0.00	\$0.00		5
Medical Appts.	2005 Free Ford	**	2006	\$17,632.00	\$0.00	10.31	\$0.00	\$0.00	\$0.00		5
Medical Appts.	05 Ford Taurus	**	2007	\$10,922.00	\$0.00	10.31	\$0.00	\$0.00	\$0.00	-	5
Medical Appts.	2011 Ford E 350	**	2011	\$34,833.50	\$6,966.70	10.31	\$718.27	\$6,966.70	\$718.27	-	5
Medical Appts.	01 Light Duty Ford Eldorado	*	2002	\$44,353.00	\$0.00		\$0.00	\$0.00	\$0.00	-	5
Medical Appts.	02 Mini Van Chevy Venture	*	2002	\$33,545.00	\$0.00		\$0.00	\$0.00	\$0.00		5
Medical Appts.	03 Ford Eldorado	*	2003	\$54,404.53	\$0.00		\$0.00	\$0.00	\$0.00		5
Medical Appts.	2008 Chevy Braun	*	2007	\$32,564.00	\$2,713.67	8	\$217.09	\$2,713.67	\$217.09		5
Medical Appts.	2008 Eldorado Aerotech	*	2008	\$52,873.00	\$8,812.17	8	\$704.97	\$8,812.17	\$704.97		5
Medical Appts.	Ford Eldorado Aerotech	*	2009	\$57,819.00	\$11,563.80	8	\$925.10	\$11,563.80	\$925.10		5
Medical Appts.	2011 Ford E450 Super Duty	*	2011	\$57,746.00	\$11,549.20	8	\$923.94	\$11,549.20	\$923.94		5
Medical Appts.	2012 Ford EIDroado Bus	*	2012	\$58,337.00	\$11,667.40	8	\$933.39	\$11,667.40	\$933.39		5
				\$482,291.53	\$53,272.94		\$4,422.77	\$53,272.94	\$4,422.77		

*
**

* Owned by Park Lawn School	Depreciation	\$3,704.50
** Owned by Park Lawn Assoc.	Depreciation	<u>\$718.27</u>
		\$4,422.77

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

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

	Program %	Cost	Program Cost	Program %	Accum. Deprec	Program Accum Deprec.
Owned by Park Lawn School	0.08	\$391,641.53	\$31,331.32	0.08	\$308,951.23	\$24,716.10
Owned by Park Lawn Assoc.	0.1031	\$90,650.00	\$9,346.02	0.1031	\$73,233.53	\$7,550.38
			<u>\$40,677.34</u>			<u>\$32,266.48</u>

on

9

Accumulated
Depreciation

\$19,929.00
\$7,333.50
\$17,632.33
\$10,922.00
\$17,416.70
\$44,353.00
\$33,545.00
\$54,404.53
\$32,564.00
\$52,873.00
\$39,991.48
\$34,691.40
\$16,528.82
\$382,184.76

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	0.185	52.73	\$632.70
Activities	2005 Ford Taurus	\$285.00	0.185	52.73	\$632.70
Activities	96 Mercury Sable Station Wagon	\$200.00	0.185	37.00	\$444.00
Activities	1998 Econo Van	\$200.00	0.185	37.00	\$444.00
Activities	2011 Ford E 350	\$585.50	0.185	108.3175	\$1,299.81
21 Totals		\$1,555.50		287.77	\$3,453.21

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	781
Pest Control	\$1,728
Plant Security	<u>\$1,037</u>
	\$3,546

Line 15 Column 1

Staff Trainer	\$11,754
QMRP	\$130,446
Res. Serv. Coord.	\$28,253
Hab. Aides	\$641,735
Psychiatrist	<u>\$9,384</u>
	\$821,572

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	\$123,784.00	
Vehicle Depreciation	\$718.00	
Equipment Depreciation	<u>\$23,571.00</u>	
		\$148,073.00

Line 35 Column 8 Community Leased equipment: Copier \$6,527, PACE \$5,010

Schedule VII. Part B

Park Lawn Association, Inc.

Building Rental not allowed

(\$131,041)

Equipment Rental not allowed

(\$1,586)

Allowable Building Interest

\$101,786

Depreciation Allowed

Building

\$144,320

Vehicle Depreciation

\$718

Equipment

\$25,037

Total Depreciation Allowed *

\$170,075

\$170,075

* 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

\$139,234.00

Schedule VIII. Part B

Central Office - 10833 S. Laporte Avenue occupies 1,717 square feet Administration and Accounting and Bookkeeping.

This is 6.96% of Total square Footage of 24,693.

These costs are distributed to each program on the percentage of budget.

The Administrative salaries are distributed on the percentage of budget basis.

Schedule IX Interest Expense

Column 10

Private Bank

This programs mortgage interest allowed from related party

\$101,786.00

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	Hrs. Worked Hrs. Paid & Accrued		
Drivers	2255	2462	\$24,289
Trainer	514	595	\$11,754
	<u>2769</u>	<u>3057</u>	<u>\$36,043</u>

Schedule XX. Page 23

Question 15 No Employee meals are served