

Facility Name & ID Number Park Lawn Home

0035527 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		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,466			5,466	13
14	TOTALS	5,466			5,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.84%

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

224 (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 12/31/91

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

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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.

Facility Name & ID Number

Park Lawn Home

0035527

Report Period Beginning:

7-1-12

Ending:

6-30-13

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	20,568	1,086	1,440	23,094		23,094		23,094		1
2	Food Purchase		66,076		66,076		66,076		66,076		2
3	Housekeeping	14,591	2,064		16,655		16,655		16,655		3
4	Laundry		907		907		907		907		4
5	Heat and Other Utilities			1,079	1,079		1,079	9,734	10,813		5
6	Maintenance	7,296	446	5,245	12,987		12,987	41,879	54,866		6
7	Other (specify):* Cable, Pest, Security		2,127		2,127		2,127		2,127		7
8	TOTAL General Services	42,455	72,706	7,764	122,925		122,925	51,613	174,538		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	15,080	9,581	4,500	29,161		29,161		29,161		10
10a	Therapy			1,760	1,760		1,760		1,760		10a
11	Activities		1,370		1,370		1,370		1,370		11
12	Social Services	4,639			4,639		4,639		4,639		12
13	CNA Training										13
14	Program Transportation		4,054	1,417	5,471		5,471		5,471		14
15	Other (specify):*	236,146			236,146		236,146		236,146		15
16	TOTAL Health Care and Programs	255,865	15,005	11,277	282,147		282,147		282,147		16
	C. General Administration										
17	Administrative	10,049			10,049		10,049	26,140	36,189		17
18	Directors Fees										18
19	Professional Services			6,894	6,894		6,894		6,894		19
20	Dues, Fees, Subscriptions & Promotions			2,758	2,758		2,758	(13)	2,745		20
21	Clerical & General Office Expenses	65,543	4,101		69,644		69,644		69,644		21
22	Employee Benefits & Payroll Taxes			95,131	95,131		95,131	(754)	94,377		22
23	Inservice Training & Education			1,196	1,196		1,196		1,196		23
24	Travel and Seminar			108	108		108		108		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			1,167	1,167		1,167	7,688	8,855		26
27	Other (specify):*										27
28	TOTAL General Administration	75,592	4,101	107,254	186,947		186,947	33,061	220,008		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	373,912	91,812	126,295	592,019		592,019	84,674	676,693		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 & ID Number

Park Lawn Home

#0035527

Report Period Beginning:

7-1-12

Ending:

6-30-13

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			1,389	1,389		1,389	35,333	36,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,258	1,258		1,258	50,709	51,967			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			55,691	55,691		55,691		55,691			34
35	Rent-Equipment & Vehicles			6,200	6,200		6,200		6,200			35
36	Other (specify):*											36
37	TOTAL Ownership			64,538	64,538		64,538	86,042	150,580			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,696	35,696		35,696		35,696			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,696	35,696		35,696		35,696			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	373,912	91,812	226,529	692,253		692,253	170,716	862,969			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 Home

0035527

Report Period Beginning: 7-1-12

Ending: 6-30-13

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	(754)	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	(13)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (767)		\$	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	171,483	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 171,483		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 170,716		37

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

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

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

Park Lawn Home

ID# 0035527

Report Period Beginning: 7-1-12

Ending: 6-30-13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Allowable Depreciation from Related Party PLH	\$ 34,882	30	1
2	Allowable Interest from Related Party PLH	50,709	32	2
3	Allowable Related Party Depreciation PLA	451	30	3
4	Allowable Related Party Utilities	9,734	5	4
5	Allowable Related Party Maintenance	41,879	6	5
6	Allowable Related Party Administrative	26,140	17	6
7	Allowable Related Party Insurance	7,688	26	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	171,483		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Home# 0035527

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	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	9,734	0	0	0	0	0	0	0	0	0	0	9,734	5
6	Maintenance	41,879	0	0	0	0	0	0	0	0	0	0	41,879	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	51,613	0	51,613	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	26,140	0	0	0	0	0	0	0	0	0	0	26,140	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	(13)	0	0	0	0	0	0	0	0	0	0	(13)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(754)	0	0	0	0	0	0	0	0	0	0	(754)	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	7,688	0	0	0	0	0	0	0	0	0	0	7,688	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	33,061	0	33,061	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	84,674	0	84,674	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Home

0035527

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

	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	35,333	0	0	0	0	0	0	0	0	0	0	35,333	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	50,709	0	0	0	0	0	0	0	0	0	0	50,709	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	86,042	0	86,042	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)	170,716	0	0	0	0	0	0	0	0	0	0	170,716	45

Facility Name & ID Number

Park Lawn Home

0035527

Report Period Beginning:

7-1-12

Ending:

6-30-13

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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 and in notes		\$	\$	1
2	V							2
3	V			Park Lawn Home, Inc. See Explanation on page 5A and in notes				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Park Lawn Home

0035527

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								1
2	Jonathan Perry	BOD						2
3	Steve Janiszewski	BOD						3
4	Bonnie Price	BOD						4
5	Robert Schwartzers	BOD						5
6	Chuck DiNolfo	BOD						6
7	James Himmel	BOD						7
8	Bill Downs	BOD						8
9	Marilyn Wnuk	BOD						9
10	Jeff Lukas	BOD						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning:

7-1-12

Ending: 6-30-13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	See page 28				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Park Lawn Home

0035527

Report Period Beginning:

7-1-12

Ending:

6-30-13

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**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1	Not Applicable						\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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			
	2011	_____	11			
	2012	_____	12			
Exempt				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035527

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	Exempt _____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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 Home

0035527 Report Period Beginning:

7-1-12 Ending:

6-30-13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facilities</u>	<u>77,381</u>	<u>1988</u>	<u>\$ 77,042</u>	1
2					2
3	TOTALS	77,381		\$ 77,042	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	15		1991	\$ 676,975	\$ 27,079	25	\$ 27,079	\$	\$ 582,837	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Garage		1995	18,306	732	25	732		13,241	9
10	Door East Side		2001	950	63	15	63		760	10
11	Bathroom Floor Tile		2001	625	42	15	42		525	11
12	Vinyl Flooring		2002	15,657		10			15,657	12
13	Storm Sewer		2002	3,780		10			3,780	13
14	4 Thermostats		2007	1,965	98	20	98		630	14
15	Sidewalks, Handrail, & Door		2007	7,815	391	20	391		2,377	15
16	8 Toilets		2009	3,573	179	20	179		730	16
17	Galv Frames Shower		2009	1,833	91	20	91		366	17
18	Door Hardware		2009	3,370	168	20	168		686	18
19	Door Hardware Installation		2009	1,140	57	20	57		230	19
20	Wall Corner Guards		2009	1,050	70	15	70		274	20
21	Washroom Wall & Floor Tile		2009	6,880	459	15	459		2,033	21
22	Additional Door Hardware		2009	732	37	20	37		142	22
23	4 Vapor Proof lights Bath Area		2010	1,075	108	10	108		369	23
24	Fence Repair		2010	1,260	126	10	126		368	24
25	Roof		2011	16,805	747	15	747		1,867	25
26	HVAC 4 Units		2012	34,035	1,324	15	1,324		1,324	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										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 Home

0035527

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	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	797,826	\$	31,771	\$	31,771	\$	628,196	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 20,441	\$ 2,615	\$ 2,615	\$	various	\$ 6,799	71
72	Current Year Purchases	8,491	495	495		10	495	72
73	Fully Depreciated Assets	33,213					33,213	73
74								74
75	TOTALS	\$ 62,145	\$ 3,110	\$ 3,110	\$		\$ 40,507	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	Se notes page 25. A small % of a few vehicles		various	\$ 12,728	\$ 1,841	\$ 1,841	\$	5	\$ 9,015	76
77										77
78										78
79										79
80	TOTALS			\$ 12,728	\$ 1,841	\$ 1,841	\$		\$ 9,015	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)	\$ 949,741	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,722	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,722	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)	\$ 677,718	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 Home

0035527

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 \$ _____

13. 06/30/2015 \$ _____

14. 06/30/2016 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 4,316 Description: PACE \$1879 Copier \$1656

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See attached listing page 26.		\$ 65.06	\$ 781	17
18					18
19					19
20					20
21	TOTAL		\$ 65.06	\$ 781	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 Home # 0035527 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	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (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 Home**# **0035527**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	2	
		Operating	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	2	
		Operating	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	\$ 614,936	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 614,936	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	3,878	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)	\$ 3,878	23
D. Non-Operating Revenue			
24	Contributions	75,098	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 75,098	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)	\$ 693,912	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	122,925	31
32	Health Care	282,147	32
33	General Administration	186,947	33
B. Capital Expense			
34	Ownership	64,538	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	35,696	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 692,253	40
41	Income before Income Taxes (line 30 minus line 40)**	1,659	41
42	Income Taxes	1,659	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	\$ 455,289	44
45	Private Pay - Net Inpatient Revenue	159,647	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)	\$ 614,936	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 Home

0035527

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
2	Assistant Director of Nursing				2
3	Registered Nurses	605	15,080	24.52	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers	144	4,639	30.12	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,905	20,568	9.79	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	364	7,296	17.37	17
18	Housekeepers	1,045	14,591	11.43	18
19	Laundry				19
20	Administrator	135	10,049	60.54	20
21	Assistant Administrator				21
22	Other Administrative	831	24,160	21.27	22
23	Office Manager	1,792	38,709	18.61	23
24	Clerical	186	2,674	13.04	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	313	5,301	14.89	28
29	Resident Services Coordinator	580	25,199	36.73	29
30	Habilitation Aides (DD Homes)	14,497	161,091	10.40	30
31	Medical Records				31
32	Other Health C: <u>Psychologist</u>	43	3,507	81.56	32
33	Other(specify) <u>See Notes page28</u>	3,096	41,048	11.40	33
34	TOTAL (lines 1 - 33)	25,536	28,327	\$ 373,912 *	\$ 13.20 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	48	\$ 1,440	1-3 35
36	Medical Director	15	3,600	9-3 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	32	1,760	10a-3 43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Phychiatrist</u>	18	4,500	10-3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	113	\$ 11,300	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
James R. Weise	Executive Director	0	\$ 9,049	Workers' Compensation Insurance	\$ 8,894	IDPH License Fee	\$		
Julie Grounds	Deputy Ex. Dir.	0	1,000	Unemployment Compensation Insurance	2,762	Advertising: Employee Recruitment		52	
				FICA Taxes	27,560	Health Care Worker Background Check			
				Employee Health Insurance	54,721	(Indicate # of checks performed <u>8</u>)		158	
				Employee Meals		Patient Background Checks <u>1</u>		10	
				Illinois Municipal Retirement Fund (IMRF)*		Membership Dues		2,048	
				Employer Match	440	License Fees		144	
				Man Ben \$754 not included in total		Subscriptions & Texts		333	
						Public Relations		13	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 10,049			Less: Public Relations Expense		(13)	
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)			\$						
C. Professional Services									
Vendor/Payee	Type		Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Wessels Sherman	Legal		\$ 74	Description	Line #	Amount	Description	Amount	
Cocalas Westberg Mommsen, LTD	Audit		847			\$	Out-of-State Travel	\$	
ADP	Computer Payroll		489						
Kronus	Computer Payroll		1,075				In-State Travel		
Comcast	Data Processing		1,200						
Community Service Partners	Data Processing		3,209				Seminar Expense		
							The ARC of Illinois	108	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,894	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 108	

* 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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Park Lawn Home

0035527

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. \$ 855 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. \$ 35,696
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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Park Lawn Home

#0035527

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

Related Party Adjustment

Park Lawn Home

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2013/2013 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL	
Total Lease	649,617	83,674	139,416	15,917	3,649	197,349	62,011	147,601	
LESS: Community Lease	84,583	19,013	36,724	7,702	499	6,453	2,664	11,528	
Related Organization	565,034	64,661	102,692	8,215	3,150	190,896	59,347	136,073	
Interest & Depreciation Related Organization	550,208	14,034	78,705	6,148	2,425	113,034	85,898	249,964	
Adjustment	-14,826	-50,627	-23,987	-2,067	-725	-77,862	26,551	113,891	
Adjust Related Organization	550,208	14,034	78,705	6,148	2,425	113,034	85,898	249,964	
Community Lease	84,583	19,013	36,724	7,702	499	6,453	2,664	11,528	
Grand Total Allowable Lease	634,791	33,047	115,429	13,850	2,924	119,487	88,562	261,492	
Other Adjustments									
Management Benefits	-9,801	-1,274	-2,451	-392	-294	-2,058	-784	-2,548	
Public Relations	5,721	23	5,591	7	5	36	14	45	
In Kind	0	0	0	0	0	0	0	0	
	PLA	PLH							
Total Interest	169,801.00	50,709.00							
Total Depreciation	306,831.58	34,881.63							
	<u>476,632.58</u>	<u>85,590.63</u>							
PLH	<u>85,590.63</u>								
	<u>562,223.21</u>					254,578.58			
Fundraising	<u>-12,015.26</u>					<u>52,253.00</u>			
						<u>306,831.58</u>			
								Mortgage Interest Vehicle Interest	

550,207.95

168,523.00
<u>1278</u>
169,801.00

D. Vehicle Depreciation

1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Program % Depr.	6 Straight Line Depr.	Program % Straight Line Dep.	7 Adjustment:	8 Life in Years
Activities	98 Econo Van	**	2005	\$7,333.50	\$0.00	6.48	\$0.00	\$0.00	\$0.00		5
Activities	05 Ford Free	**	2006	\$17,632.33	\$0.00	6.48	\$0.00	\$0.00	\$0.00		5
Activities	96 Merucry Sable	**	1996	\$19,929.00	\$0.00	6.48	\$0.00	\$0.00	\$0.00		5
Activities	11 Ford E350	**	2011	\$34,833.00	\$6,966.70	6.48	\$451.44	\$6,966.70	\$451.44		5
Activities	03 Ford Eldorado	*	2003	\$54,404.53	\$0.00	2.41	\$0.00	\$0.00	\$0.00		5
Activities	08 Chervrolet Braun	*	2007	\$32,564.00	\$6,512.80	2.41	\$156.96	\$6,512.80	\$156.96		5
Activities	08 Eldorado Aerotech	*	2008	\$52,873.00	\$10,574.60	2.41	\$254.85	\$10,574.60	\$254.85		5
Activities	09 Ford Eldorado Aerotech	*	2010	\$57,819.00	\$11,563.80	2.41	\$278.69	\$11,563.80	\$278.69		5
Activities	11 Ford E450 SuperDuty	*	2010	\$57,746.00	\$17,323.80	2.41	\$417.50	\$17,323.80	\$417.50		5
Activities	12 Ford Eldorado 220	*	2012	\$58,337.00	\$11,667.40	2.41	\$281.18	\$11,667.40	\$281.18		
				\$393,471.36	\$64,609.10		\$1,840.62	\$64,609.10	\$1,840.62		
									\$1,389.18		

* Owned by Park Lawn School Depreciation \$1,389.18

** Owned by Park Lawn Association Depreciation \$451.44
1840.62

	Program Percentag e	Cost	Total Program Cost	Program Percentag e	Accumulated Depreciation	Total Program Accum Depreciation
* Owned by Park Lawn School Depreciation	0.0241	\$313,743.53	\$7,561.22	0.0241	\$225,234.83	\$5,428.16
** Owned by Park Lawn Association Depreciation	0.0648	\$79,727.83	\$5,166.36	0.0648	\$55,344.83	\$3,586.34
		<u>\$393,471.36</u>	<u>\$12,727.58</u>		<u>\$280,579.66</u>	<u>\$9,014.50</u>

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn in unable to assign any vehicle to any one location, costs are assigned on a percentage of use basis. The vehicles with the 2.41% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

9

Accumulated
Depreciation

\$7,333.50
\$17,632.33
\$19,929.00
\$10,450.00
\$54,404.53
\$32,564.00
\$52,873.00
\$39,991.48
\$28,873.00
\$16,528.82
\$280,579.66

XII. C. Vehicle Rental

	1	2	3	Program	Program % of	4
	Use	#, Model & Year	Monthly Lease Pymt.	% of Use	Monthly Lease	Rental Expense for this Period
17 Activities		05 Ford Free	\$295.00	0.0648	\$19.12	\$229.39
Activities		98 Econo Van	\$61.00	0.0648	\$3.95	\$47.43
Activities		96 Mercury Sable	\$67.00	0.0648	\$4.34	\$52.10
Activities		11 Ford E350	\$581.00	0.0648	\$37.65	\$451.79
<hr/>						
21 Totals			\$1,004.00		\$65.06	\$780.71

Explanation Notes:

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

Line 15 Column 1

Staff Trainer	\$3,617
QMRP	\$5,301
Psych	\$3,507
Resident Services Coor	\$25,199
Facility Services Coor	\$28,323
Hab Aides	\$161,091
Driners	\$9,108
	<u>\$236,146</u>

Schedule V. Page 3 & 4

Line 5 Column 7	Allowable Related Party Costs for Utilities	\$9,734
Line 6 Column 7	Allowable Related Party Costs for Maintenance	\$41,879
Line 17 Column 7	Allowable Related Party Costs for Administrative	\$26,140
Line 26 Column 7	Allowable Related Party Costs for Insurance	\$7,688
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	\$34,882
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLA	\$451
Line 32 Column 7	Allowable Related Party Costs for Interest PLH	\$50,709
		<u>\$171,483</u>

Total Related Party Costs

Line 34 Column 4 Includes:

Office for Park Lawn School Program	\$8,026
Portion of Rent not in HUD Payments Park Lawn School costs	\$46,009
Equipment from Park Lawn Association	\$3,540
	<u>\$57,575</u>

Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	\$781
--------------------------------------	-------

Equipment Rental
Pace Vehicle Rental

\$1,656
\$1,879

\$4,316

Schedule VII. Part B Page 6

Park Lawn Association, Inc.

Depreciation of Vehicles \$451

Total Park Lawn Association Costs

Park Lawn Homes, Inc.

Utilities	\$9,734
Maintenance	\$41,879
Administration	\$26,140
Taxes/Insurance	\$7,688
Interest	\$50,709
Depreciation Bldg. & Equipment	\$34,882 *

Total Park Lawn Homes Costs \$171,032

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

Total Related Party Adjustment on Page 5A Line 49 \$171,483

Schedule VIII. Part B

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

This is 6.96% of the total square footage of 24,693.

These costs are collected in a temporary cost center and distributed out to programs on the basis of a predetermined appropriate distribution.

Administrative salaries are distributed as follows:

1. Executive Director - % of Budget
2. Acct/Bkcp - % of Budget
3. P/R Personnel - % of Staff

Schedule XI. Part D. Page 13

Line 46 Column 5 Includes only program portion of depreciation cost on vehicles. Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.

The vehicles with the 2.41% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

Schedule XII. Part C Page 14

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn is unable to assign any vehicle to any one location, costs are assigned on a percentage of use basis. The vehicles with the 2.41% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

Schedule XIII. Part B Page 15

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

Schedule XVIII. Page 19

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

Schedule XX. Page 23

Question 12 Allocated based on hours worked per department.

Question 15 No Employee meals are served.