FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0035527

Facility Name: Park Lawn Home

Address: 12615 South Kostner Avenue (Number) Alsip (City) 60803 (Zip Code)

County: Cook

Telephone Number: (708) 385-1982 **Fax #** (708) 385-8145

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Janice Leise **Telephone Number:** (708) 425-3344 Ext. 239
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7-1-09 to 6-30-10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 10-26-10 (Date)
(Type or Print Name) James R. Weise
(Title) Executive Director

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,383			5,383	13
14	TOTALS	5,383			5,383	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.32%

D. How many bed-hold days during this year were paid by the Department?
276 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] 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 [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	27,487	273	960	28,720		28,720		28,720			1
2	Food Purchase		52,989		52,989		52,989		52,989			2
3	Housekeeping	2,405	3,386		5,791		5,791		5,791			3
4	Laundry		2,194		2,194		2,194		2,194			4
5	Heat and Other Utilities			1,238	1,238		1,238	10,938	12,176			5
6	Maintenance	14,386	150	866	15,402		15,402	37,061	52,463			6
7	Other (specify):*		25		25		25		25			7
8	**TOTAL General Services**	44,278	59,017	3,064	106,359		106,359	47,999	154,358			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	16,550	7,719	6,640	30,909		30,909		30,909			10
10a	Therapy			1,568	1,568		1,568		1,568			10a
11	Activities		1,189		1,189		1,189		1,189			11
12	Social Services	9,988			9,988		9,988		9,988			12
13	CNA Training											13
14	Program Transportation	7,701	3,685	1,191	12,577		12,577		12,577			14
15	Other (specify):* See notes p 27	228,588		19	228,607		228,607		228,607			15
16	**TOTAL Health Care and Programs**	262,827	12,593	13,018	288,438		288,438		288,438			16
	C. General Administration											
17	Administrative	14,493			14,493		14,493	23,230	37,723			17
18	Directors Fees											18
19	Professional Services			7,586	7,586		7,586		7,586			19
20	Dues, Fees, Subscriptions & Promotions			2,612	2,612		2,612		2,612			20
21	Clerical & General Office Expenses	66,523	9,535		76,058		76,058		76,058			21
22	Employee Benefits & Payroll Taxes			79,257	79,257		79,257	(842)	78,415			22
23	Inservice Training & Education			825	825		825		825			23
24	Travel and Seminar			36	36		36		36			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,282	1,282		1,282	7,972	9,254			26
27	Other (specify):*											27
28	**TOTAL General Administration**	81,016	9,535	91,598	182,149		182,149	30,360	212,509			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	388,121	81,145	107,680	576,946		576,946	78,359	655,305			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:** 7-1-09 **Ending:** 6-30-10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			690	690		690	33,909	34,599			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							52,941	52,941			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			53,695	53,695		53,695		53,695			34
35	Rent-Equipment & Vehicles			4,308	4,308		4,308		4,308			35
36	Other (specify):*											36
37	**TOTAL Ownership**			58,693	58,693		58,693	86,850	145,543			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			34,716	34,716		34,716		34,716			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			34,716	34,716		34,716		34,716			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	388,121	81,145	201,089	670,355		670,355	165,209	835,564			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: 7-1-09 Ending: 6-30-10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(842)	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				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (842)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	166,051	5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 166,051		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 165,209		37

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

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

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

Park Lawn Home

ID# 0035527

Report Period Beginning: 7-1-09

Ending: 6-30-10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Related Party Utilities	$ 10,938	5	1
2	Allowable Related Party Maintenance	37,061	6	2
3	Allowable Administrative	23,230	17	3
4	Allowable Related Party Insurance	7,972	26	4
5	Allowable Related Party Deprecitaion PLH	33,623	30	5
6	Allowable Related Party Interest PLH	52,934	32	6
7	Allowable Related Pary Interest PLA	7	32	7
8	Allowable Related Party Depreciation PLA	286	30	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**	166,051		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7-1-09 **Ending:** 6-30-10

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	10,938	0	0	0	0	0	0	0	0	0	0	10,938	5
6	Maintenance	37,061	0	0	0	0	0	0	0	0	0	0	37,061	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	47,999	0	0	0	0	0	0	0	0	0	0	47,999	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	23,230	0	0	0	0	0	0	0	0	0	0	23,230	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(842)	0	0	0	0	0	0	0	0	0	0	(842)	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	7,972	0	0	0	0	0	0	0	0	0	0	7,972	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	30,360	0	0	0	0	0	0	0	0	0	0	30,360	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	78,359	0	0	0	0	0	0	0	0	0	0	78,359	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7-1-09 **Ending:** 6-30-10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	33,909	0	0	0	0	0	0	0	0	0	0	33,909	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	52,941	0	0	0	0	0	0	0	0	0	0	52,941	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**	86,850	0	0	0	0	0	0	0	0	0	0	86,850	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	165,209	0	0	0	0	0	0	0	0	0	0	165,209	45

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Park Lawn Assoc.	Oak Lawn	Support 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Park Lawn Association, Inc. 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: 7-1-09 Ending: 6-30-10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 7-1-09 Ending: 6-30-10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 7-1-09 Ending: 6-30-10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Ford Credit		X	Ford Freestyle	$331.93	4-8-06	$ 17,632	$ 2,928	4-8-11	4.9000	$ 7	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$331.93		$ 17,632	$ 2,928			$ 7	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 17,632	$ 2,928			$ 7	15

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

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

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

Facility Name & ID Number Park Lawn Home **#** 0035527 **Report Period Beginning:** 7-1-09 **Ending:** 6-30-10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

Exempt

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 7-1-09 Ending: 6-30-10

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15			1991	$ 676,975	$ 27,079	25	$ 27,079	$	$ 501,600	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1995	18,306	732	25	732		11,044	9
10	Door East Side			2001	950	63	15	63		570	10
11	Bathroom Floor Tile			2001	625	42	15	42		399	11
12	Vinyl Flooring			2002	15,657	1,566	10	1,566		12,656	12
13	Storm Sewer			2002	3,780	378	10	378		3,055	13
14	4 Thermostats			2007	1,965	98	20	98		336	14
15	Sidewalks, Handrail & Door			2007	7,815	391	20	391		1,206	15
16	8 Toilets			2009	3,573	179	20	179		194	16
17	Galv Frames Shower			2009	1,833	91	20	91		92	17
18	Door Hardware			2009	3,370	168	20	168		182	18
19	Door Hardware Installation			2009	1,140	57	20	57		62	19
20	Wall Corner Guards			2009	1,050	64	15	64		64	20
21	Washroom wall & Floor Tile			2009	6,880	382	15	382		382	21
22	Additional Door Hardware			2009	732	31	20	31		31	22
23	4 Vapor Proof lights bath area			2010	1,075	45	10	45		45	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

*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: 7-1-09 Ending: 6-30-10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)		$ 745,726	$ 31,366		$ 31,366	$	$ 531,918	70

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 10,710	$ 2,167	$ 2,167	$	various	$ 5,316	71
72	Current Year Purchases	3,040	90	90		various	90	72
73	Fully Depreciated Assets	29,126					29,126	73
74								74
75	TOTALS	$ 42,876	$ 2,257	$ 2,257	$		$ 34,532	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See attached Listing page 25.	A small % of a few vehicles		$ 9,112	$ 976	$ 976	$	5	$ 5,125	76
77										77
78										78
79										79
80	TOTALS			$ 9,112	$ 976	$ 976	$		$ 5,125	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)	$ 874,756	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,599	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,599	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)	$ 571,575	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: 7-1-09 Ending: 6-30-10

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 [X] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	06/2011	$
13.	06/2012	$
14.	06/2013	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 1,283 Description: PACE $1283
(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 listing on page 26.		$ 32.03	$ 384	17
18					18
19					19
20					20
21	TOTAL		$ 32.03	$ 384	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: 7-1-09 Ending: 6-30-10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 90 OJT

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(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.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-10 (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	$ 405,355	$	1
2	Cash-Patient Deposits	93,912		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	7,210		5
6	Prepaid Insurance	52,686		6
7	Other Prepaid Expenses	775		7
8	Accounts Receivable (owners or related parties)	976,544		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,536,482	$	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	416,687		15
16	Equipment, at Historical Cost	(312,345)		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 104,342	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,640,824	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 159,688	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	94,586		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	481,636		30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,064)		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)**	$ 733,846	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	620,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Equipment & Leases	170,735		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 790,735	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,524,581	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 116,243	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,640,824	$	48

***(See instructions.)**

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7-1-09 **Ending:** 6-30-10

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.**

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 622,589	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 622,589	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	1,734	10
11	CNA Training Reimbursements	2,066	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)**	$ 3,800	23
	D. Non-Operating Revenue		
24	Contributions	45,830	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 45,830	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)**	$ 672,219	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	106,359	31
32	Health Care	288,438	32
33	General Administration	182,149	33
	B. Capital Expense		
34	Ownership	58,693	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	34,716	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 670,355	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,864	41
42	**Income Taxes**	1,864	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$	43

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

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

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	582	607	14,592	24.04	3
4	Licensed Practical Nurses	72	72	1,958	27.19	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	468	521	9,988	19.17	11
12	Dietician					12
13	Food Service Supervisor	347	415	6,421	15.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,932	2,101	21,066	10.03	15
16	Dishwashers					16
17	Maintenance Workers	921	1,058	14,386	13.60	17
18	Housekeepers	283	289	2,405	8.32	18
19	Laundry					19
20	Administrator	329	393	14,493	36.88	20
21	Assistant Administrator					21
22	Other Administrative	1,146	1,351	28,388	21.01	22
23	Office Manager	1,896	2,080	38,135	18.33	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	473	686	22,222	32.39	29
30	Habilitation Aides (DD Homes)	14,654	15,515	169,882	10.95	30
31	Medical Records					31
32	Other Health C: Psychologist	44	44	3,606	81.95	32
33	Other(specify) See Notes p. 29	2,948	3,229	40,579	12.57	33
34	TOTAL (lines 1 - 33)	26,095	28,361	$ 388,121 *	$ 13.69	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$	1-3	35
36	Medical Director			9-3	36
37	Medical Records Consultant			10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist			10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Weise	Executive Director	0	$ 8,555
Julia Grounds	Deputy Executive Dir.	0	6,297
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 14,852

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wessels & Pautsch	HR Consulting	$ 55
Cocalas, Westberg Mommsen	Audit	846
ADP	P/R	3,546
Intrigration Works	Data Processing	3,139
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 7,586

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,949
Unemployment Compensation Insurance	4,591
FICA Taxes	27,935
Employee Health Insurance	36,860
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer Match TSA	2,080
Man Ben of $842 is not incluede in total	
TOTAL (agree to Schedule V, line 22, col.8)	$ 78,415

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	108
Health Care Worker Background Check	155
(Indicate # of checks performed 5)	
Patient Background Checks 0	
Subscriptions & Texts	239
Membership Dues	1,989
License Fees Other	121
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,612

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Illinois Assoc. of Rehab Facilities	36
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 36

**See instructions.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-09 Ending: 6-30-10

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	Amount of Expense Amortized Per Year								
					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:** 7-1-09 **Ending:** 6-30-10

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. $ **703** 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. $ **34,716**
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.

Related Party Adjustment

Park Lawn Home

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2009/2010 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL
Total Lease	596,737	76,278	127,351	12,786	3,508	171,155	58,114	147,545
LESS: Community Lease	64,532	13,603	26,572	5,429	427	4,942	2,027	11,532
Related Organization	532,205	62,675	100,779	7,357	3,081	166,213	56,087	136,013
Interest & Depreciation Related Organization	569,752	17,545	78,973	6,168	2,445	94,608	86,854	283,159
Adjustment	37,547	(45,130)	(21,806)	(1,189)	(636)	(71,605)	30,767	147,146
Adjust Related Organization	569,752	17,545	78,973	6,168	2,445	94,608	86,854	283,159
Community Lease	64,532	13,603	26,572	5,429	427	4,942	2,027	11,532
Grand Total Allowable Lease	634,284	31,148	105,545	11,597	2,872	99,550	88,881	294,691
Other Adjustments								
Management Benefits	(10,954)	(1,473)	(2,719)	(478)	(328)	(2,257)	(842)	(2,857)
Public Relations	(6,752)	0	(6,752)	0	0	0	0	0
In Kind	0	0	0	0	0	0	0	0

	PLA	PLH
Total Interest	217,769.00	52,934.00
Total Depreciation	282,250.00	33,623.00
	500,019.00	86,557.00
PLH	86,557.00	
	586,576.00	
Fundraising	-16,824.00	
	569,752.00	

PLA Depreciation	
Bldg. Depreciation	232,401.00
Equipment Depreciation	49,849.00
	282,250.00

Mortgage Intere	217,526.00
Vehicle Interest	243
	217,769.00

D. Vehicle Depreciation

1 Use	2 ake, Model & Year	3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Program % Depre.	6 Straight Line Depr.	Program % Straight Line Dep.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation
Activities	98 Econo Van **	2005	$7,333.50	$1,466.70	5.72	$83.90	$1,466.70	$83.90		5	$5,622.30
Activities	05 Ford Free **	2006	$17,632.33	$3,526.47	5.72	$201.71	$3,526.47	$201.71		5	$11,754.90
Activities	96 Merucry Sab **	1996	$19,929.00	$0.00	5.72	$0.00	$0.00	$0.00		5	$19,929.00
Activities	03 Ford Eldorad *	2003	$54,404.53	$6,347.20	2.945	$186.93	$6,347.20	$186.93		5	$54,404.53
Activities	08 Chervrolet Bl *	2007	$32,564.00	$6,512.80	2.945	$191.80	$6,512.80	$191.80		5	$10,311.93
Activities	08 Eldorado Aer *	2008	$52,873.00	$10,574.60	2.945	$311.42	$10,574.60	$311.42		5	$12,337.03
			$184,736.36	$28,427.77		$975.76	$28,427.77	$975.76			$114,359.69

* Owned by Park Lawn School	Depreciation	$690.15
** Owned by Park Lawn Association	Depreciation	$285.61
		975.76

		Program Percentage	Cost	Total Program Cost	Program Percentage	Accumulated Depreciation	Total Program Accum Depreciation
* Owned by Park Lawn School	Depreciation	0.02945	$139,841.53	$4,118.33	0.02945	$77,053.49	$2,269.23
** Owned by Park Lawn Association	Deprecia	0.572	$44,894.83	$4,993.17	0.572	$4,993.17	$2,856.09
			$184,736.36	$9,111.50		$82,046.66	$5,125.32

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 2.945% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

XII. C. Vehicle Rental

	1 Use	2 e, Model & Year	3 Monthly Lease Pymt.	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
17	Activities	05 Ford Free	$300.00	0.0572	$17.16	$205.92
	Activities	98 Econo Van	$130.00	0.0572	$7.44	$89.23
	Activities	96 Mercury Sable	$130.00	0.0572	$7.44	$89.23
21	Totals		$560.00		$32.03	$384.38

Explanation Notes:

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

Line 15 Column 1

Staff Trainer	$2,137
Psych	$3,606
Resident Services Coor	$22,222
Facility Services Coor	$30,741
Hab Aides	$169,882
	$228,588

Schedule V. Page 3 & 4

Line 5 Column 7	Allowable Related Party Costs for Utilities	$10,938
Line 6 Column 7	Allowable Related Party Costs for Maintenance	$37,061
Line 17 Column 7	Allowable Related Party Costs for Administrative	$23,230
Line 26 Column 7	Allowable Related Party Costs for Insurance	$7,972
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	$33,623
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLA	$286
Line 32 Column 7	Allowable Related Party Costs for Interest PLA	$7

Line 32 Column 7	Allowable Related Party Costs for Interest PLH	$52,934
		$166,051

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	$44,014
Equipment from Park Lawn Association	$1,655
	$53,695

Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	$384
Equipment Rental	$2,641
Pace Vehicle Rental	$1,283
	$4,308

Schedule VII. Part B Page 6

Park Lawn Association, Inc.

Depreciation of Vehicles		$286
Interest on Vehicles 243 X 3%		$7
Total Park Lawn Association Costs		$293

Park Lawn Homes, Inc.

Utilities	$10,938	
Maintenance	$37,061	
Administration	$23,230	
Taxes/Insurance	$7,972	
Interest	$52,934	
Depreciation Bldg. & Equipment	$33,623 *	
Total Park Lawn Homes Costs		$165,758

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

Total Related Party Adjustment on Page 5A Line 49 $166,051

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/Bkkp - % of Budget
3. P/R Personnel - % of Staff

Schedule IX. Page 9
Line 15 $7 is the allowable portion of program interest, see page 5 line 35

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 2.945% usuage are wheel chair accessible and must be used to transport wheelchair cound clients.

Schedule XII. Part C Page 14
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 2.945% usuage 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.