FOR BHF USE

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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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0027078

Facility Name: Park Lawn Center

Address: 5831 West 115th Street (Number) Alsip (City) 60803 (Zip Code)

County: Cook

Telephone Number: (708) 396-1117 **Fax #** (708) 396-1186

HFS ID Number:

Date of Initial License for Current Owners: 9-22-82

Type of Ownership:

X	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 7-1-10 to 6-30-11 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) 10-26-11 (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 Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	41	Intermediate/DD	41	14,965	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	14,965	7

B. Census-For the entire report period.

	1 Level of Care	2 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	14,319			14,319	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,319			14,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.68%

D. How many bed-hold days during this year were paid by the Department?
230 (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 09/22/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/22/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] 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: 6-30-11 Fiscal Year: 6-30-11

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	130,545	4,539	5,350	140,434		140,434		140,434			1
2	Food Purchase		166,906		166,906		166,906		166,906			2
3	Housekeeping	52,898	6,755		59,653		59,653		59,653			3
4	Laundry	11,562	9,116		20,678		20,678		20,678			4
5	Heat and Other Utilities			65,953	65,953		65,953		65,953			5
6	Maintenance	9,742	21,629	26,199	57,570		57,570		57,570			6
7	Other (specify):*		3,229		3,229		3,229		3,229			7
8	TOTAL General Services	204,747	212,174	97,502	514,423		514,423		514,423			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	292,882	61,391	21,448	375,721		375,721		375,721			10
10a	Therapy			7,838	7,838		7,838		7,838			10a
11	Activities	34,793	309		35,102		35,102		35,102			11
12	Social Services	12,371			12,371		12,371		12,371			12
13	CNA Training											13
14	Program Transportation	19,172	8,740	3,253	31,165		31,165		31,165			14
15	Other (specify):* See Notes p. 28	853,026		614	853,640		853,640		853,640			15
16	TOTAL Health Care and Programs	1,212,244	70,440	41,553	1,324,237		1,324,237		1,324,237			16
	C. General Administration											
17	Administrative	48,608			48,608		48,608		48,608			17
18	Directors Fees											18
19	Professional Services			29,569	29,569		29,569		29,569			19
20	Dues, Fees, Subscriptions & Promotions			4,052	4,052		4,052	(171)	3,881			20
21	Clerical & General Office Expenses	125,131		24,839	149,970		149,970		149,970			21
22	Employee Benefits & Payroll Taxes			313,243	313,243		313,243	(2,113)	311,130			22
23	Inservice Training & Education			2,829	2,829		2,829		2,829			23
24	Travel and Seminar			54	54		54		54			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			19,991	19,991		19,991		19,991			26
27	Other (specify):*											27
28	TOTAL General Administration	173,739		394,577	568,316		568,316	(2,284)	566,032			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,590,730	282,614	533,632	2,406,976		2,406,976	(2,284)	2,404,692			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 Center #0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			4,099	4,099	(1,269)	2,830	170,193	173,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			337	337		337	140,371	140,708			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			131,048	131,048		131,048	(131,048)				34
35	Rent-Equipment & Vehicles			16,648	16,648		16,648	(4,993)	11,655			35
36	Other (specify):* Unallowed Depreciation					1,269	1,269		1,269			36
37	TOTAL Ownership			152,132	152,132		152,132	174,523	326,655			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			127,368	127,368		127,368		127,368			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			127,368	127,368		127,368		127,368			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,590,730	282,614	813,132	2,686,476		2,686,476	172,239	2,858,715			45

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	(2,113)	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	(171)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,284)		$	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	174,523	5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 174,523		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 172,239		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.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Park Lawn Center

ID# 0027078

Report Period Beginning: 7-1-10

Ending: 6-30-11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Depreciation from Related Party	$ 170,193	30	1
2	Allowable Interest from Related Party	140,371	32	2
3	Rent-Facility & Grounds	(131,048)	34	3
4	Rent - Equipment & Vehicles	(4,993)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	174,523		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Park Lawn Center **#** 0027078 **Report Period Beginning:** 7-1-10 **Ending:** 6-30-11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(171)	0	0	0	0	0	0	0	0	0	0	(171)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,113)	0	0	0	0	0	0	0	0	0	0	(2,113)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,284)	0	0	0	0	0	0	0	0	0	0	(2,284)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,284)	0	0	0	0	0	0	0	0	0	0	(2,284)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center **#** 0027078 **Report Period Beginning:** 7-1-10 **Ending:** 6-30-11

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	170,193	0	0	0	0	0	0	0	0	0	0	170,193	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	140,371	0	0	0	0	0	0	0	0	0	0	140,371	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(131,048)	0	0	0	0	0	0	0	0	0	0	(131,048)	34
35	Rent-Equipment & Vehicles	(4,993)	0	0	0	0	0	0	0	0	0	0	(4,993)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	174,523	0	0	0	0	0	0	0	0	0	0	174,523	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)	172,239	0	0	0	0	0	0	0	0	0	0	172,239	45

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

VII. RELATED PARTIES

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

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

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

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

1 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, See Explanation on pare 5A	N/A	$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jonathan Perry	BOD						1
2	Steve Janiszewski	BOD						2
3	Robert Schwartzers	BOD						3
4	Bonnie Price	BOD						4
5	Chuck DiNolfo	BOD						5
6	James Himmel	BOD						6
7	Pat O'Brien	BOD						7
8	Robert Barnes	BOD						8
9	Halima Jabulani	BOD						9
10	Cheri Boublis	BOD						10
11	Tom Olofsson	BOD						11
12	Maureen Reilly	BOD						12
13	Fred Zimmy	BOD						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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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 Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	Private Bank		X	Mortgage	interest	12-29-05	$ 3,000,000	$ 2,811,229	12-15-12	4.8750	$ 140,312	1
2	Ford Credit		X	Ford Freestyle	$331.93	4-8-06	17,632		4-8-11	4.9000	59	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$331.93		$ 3,017,632	$ 2,811,229			$ 140,371	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,017,632	$ 2,811,229			$ 140,371	15

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

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

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

Facility Name & ID Number Park Lawn Center **#** 0027078 **Report Period Beginning:** 7-1-10 **Ending:** 6-30-11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

Not Applicable

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027078

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Not Applicable	$	$
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [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? [ ] (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: Completely Amoritized 6-30-08
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____
4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facilities	124,955	1981	$ 190,000	1
2					2
3	TOTALS	124,955		$ 190,000	3

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	41		1982		$ 210,000	$ 6,000	35	$ 6,000	$	$ 172,636	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing, Heat & AC			1982	165,500	4,729	35	4,729		137,141	9
10	Electric & Fixtures			1982	81,400	2,326	35	2,326		67,454	10
11	Elevator			1982	33,385	954	35	954		27,666	11
12	Concrete			1982	43,171	1,233	35	1,233		19,961	12
13	Sprinklers			1982	22,085	631	35	631		18,279	13
14	Bath. Access.			1982	2,450	70	35	70		2,030	14
15	Construction Int			1982	18,357	525	35	525		15,225	15
16	Carpentry			1982	23,800	680	35	680		19,720	16
17	Windows			1982	33,088	945	35	945		27,408	17
18	Ceramic Tile			1982	10,621	303	35	303		8,787	18
19	Painting			1982	10,166	290	35	290		8,410	19
20	Various Construction Materials			1982	75,966	2,170	35	2,170		62,930	20
21	Permits			1982	1,803	52	35	52		1,508	21
22	Architect Fee			1982	29,577	844	35	844		24,476	22
23	Construction Manager			1982	40,000	1,143	35	1,143		33,147	23
24	Demolition			1982	6,858	196	35	196		5,684	24
25	Windows			1983	4,258		25			4,258	25
26	Sewer & Sump Pump			1983	4,933		10			4,933	26
27	Windows			1986	850	26	25	26		850	27
28	Generator			1986	15,785		20			15,785	28
29	Fence/Gate			1993	2,053		10			2,053	29
30	Roof Repair			1997	26,382	1,759	15	1,759		26,236	30
31	Tile Main area and Floor patch			2001	5,857	586	10	586		5,712	31
32	Compressor			2004	2,475	165	15	165		1,155	32
33	4 stage Chiller			2005	1,285	85	15	85		589	33
34	Elevator Pump			2005	6,200	620	10	620		2,893	34
35	General Contractor Job Superintendent			2007	180,564	4,514	40	4,514		19,185	35
36	General Contractor Fees			2007	210,949	5,274	40	5,274		22,414	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Ins & Permits	2007	$ 184,211	$ 4,605	40	$ 4,605	$	$ 19,572	37
38	Estimate Contingency	2007	1,471	37	40	37		157	38
39	Roofing	2007	185,247	4,631	40	4,631		19,682	39
40	Metal Wall Panels	2007	17,760	444	40	444		1,887	40
41	Sun Screens	2007	46,408	1,160	40	1,160		4,930	41
42	HVAC	2007	230,756	5,769	40	5,769		24,518	42
43	Electrical	2007	366,412	9,160	40	9,160		38,930	43
44	Final Cleaning	2007	1,145	29	40	29		123	44
45	Selective Demolition	2007	39,425	986	40	986		4,190	45
46	Earthwork	2007	103,726	2,593	40	2,593		11,020	46
47	Asphalt Paving	2007	56,525	1,413	40	1,413		6,002	47
48	Fencing	2007	12,113	303	40	303		1,288	48
49	Landscaping	2007	23,679	592	40	592		2,516	49
50	Concrete	2007	148,644	3,716	40	3,716		15,793	50
51	Steel	2007	18,829	471	40	471		2,001	51
52	Carpentry	2007	592,248	14,806	40	14,806		63,985	52
53	Millwork	2007	35,126	878	40	878		3,732	53
54	Drywall & Acoustical	2007	233,229	5,831	40	5,831		24,781	54
55	Calking	2007	4,232	106	40	106		450	55
56	Doors & Hardware	2007	77,373	1,934	40	1,934		8,220	56
57	R/R Coiling Doors	2007	3,148	79	40	79		335	57
58	Overhead Doors	2007	3,450	86	40	86		366	58
59	Al;uminum Entrances	2007	67,203	1,680	40	1,680		7,140	59
60	Wood Windows	2007	82,549	2,064	40	2,064		8,772	60
61	Tile & Carpet	2007	126,869	3,172	40	3,172		13,481	61
62	Painting	2007	47,690	1,192	40	1,192		5,066	62
63	Toilet Acc/Floor Mat/ Fire Ext/Tack board	2007	15,955	399	40	399		1,596	63
64	Acrovyn Wall Protection	2007	20,486	512	40	512		2,176	64
65	Fire Protection	2007	112,086	2,802	40	2,802		11,909	65
66	Plumbing	2007	387,850	9,696	40	9,696		41,208	66
67	Low Voltage	2007	20,482	512	40	512		2,176	67
68	Fire Hydrant	2007	9,975	249	40	249		1,059	68
69	Two Monument Signs	2007	4,750	119	40	119		505	69
70	TOTAL (lines 4 thru 69)		$ 4,550,870	$ 118,146		$ 118,146	$	$ 1,108,091	70

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12A, Carried Forward		$ 4,550,870	$ 118,146		$ 118,146	$	$ 1,108,091	1
2	Metal Studs	2007	13,225	331	40	331		1,406	2
3	Architect	2007	348,281	8,707	40	8,707		37,005	3
4	Legal	2007	4,095	102	40	102		434	4
5	Soil Boring	2007	1,200	30	40	30		128	5
6	Survey	2007	2,300	58	40	58		246	6
7	Phone System	2007	12,262	307	40	307		1,304	7
8	Title Company Fees	2007	5,410	135	40	135		574	8
9	General Contractor Job Superintendent	2007	22,050	551	40	551		1,929	9
10	General Contractor Fees	2007	71,712	1,793	40	1,793		6,275	10
11	Roofing	2008	53,578	1,339	40	1,339		4,587	11
12	Sun Screens	2008	27,467	687	40	687		2,404	12
13	HVAC	2008	42,548	1,064	40	1,064		3,698	13
14	Electrical	2008	42,114	1,053	40	1,053		3,685	14
15	Selective Demolition	2008	2,018	50	40	50		175	15
16	Earthwork	2008	5,459	136	40	136		476	16
17	Asphalt Paving	2008	2,975	74	40	74		259	17
18	Fencing	2008	638	16	40	16		56	18
19	Landscaping	2008	8,958	224	40	224		827	19
20	Concrete	2008	7,823	196	40	196		686	20
21	Steel	2008	3,641	91	40	91		319	21
22	Carpentry	2008	31,944	799	40	799		2,796	22
23	Millwork	2008	11,554	289	40	289		1,011	23
24	Drywall & Acoustical	2008	54,781	1,370	40	1,370		4,795	24
25	Doors & Hardware	2008	5,007	125	40	125		437	25
26	Aluminum Entrances	2008	8,517	213	40	213		745	26
27	Wood Windows	2008	1,395	35	40	35		122	27
28	Tile & Carpet	2008	12,794	320	40	320		1,120	28
29	Painting	2008	23,111	578	40	578		2,200	29
30	Toilet Acc/Floor/Mat/ Fire Ext/Tack Board	2008	2,465	62	40	62		217	30
31	Acrovyn Wall Protection	2008	472	12	40	12		42	31
32	Fire Protection	2008	37,852	946	40	946		3,311	32
33	Plumbing	2008	41,841	1,043	40	1,043		3,713	33
34	TOTAL (lines 1 thru 33)		$ 5,460,357	$ 140,882		$ 140,882	$	$ 1,195,073	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12B, Carried Forward		$ 5,460,357	$ 140,882		$ 140,882	$	$ 1,195,073	1
2	Low Voltage	2008	23,516	588	40	588		1,176	2
3	Fire Hydrant	2008	525	13	40	13		26	3
4	Two Monument Signs	2008	12,250	306	40	306		612	4
5	Metal Studs	2008	4,295	107	40	107		214	5
6	Architect	2008	1,969	49	40	49		98	6
7	Phone System	2008	10,053	251	40	251		502	7
8	Aquarium	2009	7,827	783	10	783		1,566	8
9	Artwork	2009	1,510	151	10	151		302	9
10	Dedication Sign	2009	2,553	54	40	54		108	10
11	Two Electric Heaters	2009	1,121	28	40	28		56	11
12	Vinyl Tile Front Entrance	2009	1,468	37	40	37		74	12
13	Wallcovering and Chair Rail	2009	3,992	100	40	100		200	13
14	Masonary Restoration	2009	3,685	184	20	184		368	14
15	Tuckpointing Bldg.	2010	9,800	490	20	490		817	15
16	Parking Lot Lighting	2010	3,480	174	20	174		247	16
17	Pump Work	2010	1,522	101	15	101		143	17
18	Two Marley Heaters	2010	2,618	261	10	261		326	18
19	Door Hardware	2010	1,488	74	20	74		74	19
20	Crack filling/sealcoating of lot	2010	4,747	435	10	435		435	20
21	Exhaust Fan add on Elevator Room	2011	2,775	69	10	69		69	21
22	Canopy Sprinkler Installation	2011	9,290	52	15	52		52	22
23	Completion of River Rock to CR Drive	2011	1,097		10				23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,571,938	$ 145,189		$ 145,189	$	$ 1,202,538	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	$ 231,080	$ 23,533	$ 23,533	$	various	$ 92,083	71
72	Current Year Purchases	18,642	1,279	1,279		various	1,279	72
73	Fully Depreciated Assets	141,866					141,866	73
74								74
75	TOTALS	$ 391,588	$ 24,812	$ 24,812	$		$ 235,228	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See notes page 25.			$ 30,294	$ 3,022	$ 3,022	$	5	$ 21,809	76
77										77
78										78
79										79
80	TOTALS			$ 30,294	$ 3,022	$ 3,022	$		$ 21,809	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,183,820	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 173,023	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 173,023	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,459,575	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 Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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 7-1-10
Ending 6-30-11

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

	Fiscal Year Ending	Annual Rent
12.	06/30/2012	$ 125,592
13.	06/30/2013	$ 125,592
14.	06/30/2014	$ 125,592

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 10,976 Description: Copiers $7,090, PACE $3,886
(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.		$ 330.63	$ 3,968	17
18					18
19					19
20					20
21	TOTAL		$ 330.63	$ 3,968	21

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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 Facility Drop-outs	2 Facility Completed	3 Contract	4 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	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	18

(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 Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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 Center **#** 0027078 **Report Period Beginning:** 7-1-10 **Ending:** 6-30-11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-11 **(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	$ 95,807	$	1
2	Cash-Patient Deposits	93,597		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	209,137		5
6	Prepaid Insurance	51,281		6
7	Other Prepaid Expenses	212		7
8	Accounts Receivable (owners or related parties)	1,281,689		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,731,723	$	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	484,039		16
17	Accumulated Depreciation (book methods)	(349,949)		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)**	$ 134,090	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,865,813	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 223,236	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	95,574		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	547,394		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,792		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)**	$ 870,996	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	878,574		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)**	$ 878,574	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,749,570	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 116,243	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,865,813	$	48

***(See instructions.)**

Facility Name & ID Number Park Lawn Center # 0027078 **Report Period Beginning:** 7-1-10 **Ending:** 6-30-11

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 Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	$ 2,415,183	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,415,183	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	4,620	10
11	CNA Training Reimbursements	30,427	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)**	$ 35,047	23
	D. Non-Operating Revenue		
24	Contributions	242,066	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 242,066	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,692,296	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	514,423	31
32	Health Care	1,324,237	32
33	General Administration	568,316	33
	B. Capital Expense		
34	Ownership	152,132	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	127,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,686,476	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,820	41
42	**Income Taxes**	5,820	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 Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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	1,834	2,106	$ 62,590	$ 29.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,278	3,609	94,832	26.28	3
4	Licensed Practical Nurses	4,556	5,344	135,460	25.35	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,958	3,387	34,793	10.27	10
11	Social Service Workers	392	420	12,371	29.45	11
12	Dietician					12
13	Food Service Supervisor	1,388	1,664	26,655	16.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,791	9,391	103,890	11.06	15
16	Dishwashers					16
17	Maintenance Workers	1,222	1,873	9,742	5.20	17
18	Housekeepers	4,596	5,276	52,898	10.03	18
19	Laundry	1,173	1,249	11,562	9.26	19
20	Administrator	812	1,027	48,608	47.33	20
21	Assistant Administrator					21
22	Other Administrative	3,228	3,823	85,321	22.32	22
23	Office Manager	1,821	2,085	39,810	19.09	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,762	7,409	114,120	15.40	28
29	Resident Services Coordinator	660	770	25,297	32.85	29
30	Habilitation Aides (DD Homes)	52,347	60,308	664,057	11.01	30
31	Medical Records					31
32	Other Health C: Psychologist	122	122	9,928	81.38	32
33	Other(specify) Driver, Dietary La	4,120	4,557	58,796	12.90	33
34	TOTAL (lines 1 - 33)	100,060	114,420	$ 1,590,730 *	$ 13.90	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	268	$ 5,350	1-3	35
36	Medical Director	67	8,400	9-3	36
37	Medical Records Consultant	16	560	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	143	7,838	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	22	5,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	516	$ 27,648		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	227	$ 13,655	10-3	50
51	Licensed Practical Nurses	46	1,733	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	273	$ 15,388		53

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James R. Weise	Executive Director	0	$ 28,835
Julie Grounds	Deputy Ex. Dir.	0	19,773
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,608

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
James Himmel	Legal	$ (1,846)
Cocalas Westberg Mommsen	Audit	2,870
Kronos	Computer P/R	6,196
ADP	Computer P/R	8,671
Intelligent Solutions	Data Processing	2,370
Peter Ptak	Data Processing	3,228
Comcast	Data Processing	783
CDW	Data Processing	718
Southwest Service Providers	Data Processing	96
JMT Consultant	Data Processing	340
Community Service Partners	Data Processing	6,143
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 29,569

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,322
Unemployment Compensation Insurance	32,333
FICA Taxes	114,588
Employee Health Insurance	123,764
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer Match	5,123
Man Ben $2113 not included in total	
TOTAL (agree to Schedule V, line 22, col.8)	$ 311,130

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	884
Health Care Worker Background Check	619
(Indicate # of checks performed 20)	
Patient Background Checks 1	
Membership Dues	1,674
License Fees Other	311
Subscriptions & Texts	393
Public Relations	171
Less: Public Relations Expense	(171)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,881

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
ARC of Illinois Annual Convention	54
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 54

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-10 Ending: 6-30-11

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 Center **#** 0027078 **Report Period Beginning:** 7-1-10 **Ending:** 6-30-11

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. $ **23,943** 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. $ **127,368**
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 permietted**
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 Center

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2010/2011 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL
Total Lease	610,126	78,470	126,755	13,685	3,592	182,711	57,216	147,697
LESS: Community Lease	58,968	13854	25940	5,650	153	3,400	1,457	8,514
Related Organization	551,158	64,616	100,815	8,035	3,439	179,311	55,759	139,183
Interest & Depreciation Related Organization	569,355	16,602	80,247	6,239	2,485	92,508	86,343	284,932
Adjustment	18,198	(48,014)	(20,568)	(1,797)	(954)	(86,803)	30,584	145,749
Adjust Related Organization	569,355	16,602	80,247	6,239	2,485	92,508	86,343	284,932
Community Lease	58,968	13,854	25,940	5,650	153	3,400	1,457	8,514
Grand Total Allowable Lease	628,324	30,456	106,187	11,888	2,638	95,908	87,800	293,446
Other Adjustments								
Management Benefits	(8,100)	(1,089)	(2,010)	(353)	(243)	(1,669)	(623)	(2,113)
Public Relations	8,736	24	8,389	14	2	113	31	163
In Kind	0	0	0	0	0	0	0	0

	PLA	PLH
Total Interest	209,260.50	52,253.54
Total Depreciation	289,572.06	33,794.34
	498,832.56	86,047.88
PLH	86,047.88	
	584,880.44	
Fundraising	-15,524.87	
	569,355.57	

PLA Depreciation	
Bldg. Depreciation	235,975.06
Equipment Depreciation	53,597.00
	289,572.06

Mortgage Intere	208,525.81
Vehicle Interes	734.69
	209,260.50

1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Prog. % of Depreciation	6 Straight Line Depreciation	Program % of Straight Line Depr.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation
Medical Appts.	96 Mercury Sable	**	1996	$19,929.00	0	9.1	0	0	0		5	$19,929.00
Medical Appts.	98 Econo Van	**	2004	$7,333.50	$0.00	9.1	$0.00	$0.00	$0.00		5	$7,333.50
Medical Appts.	2005 Free Ford	**	2006	$17,632.00	$2,350.96	9.1	$213.94	$2,350.96	$213.94		5	$17,632.33
Medical Appts.	05 Ford Taurus	**	2007	$10,922.00	$2,184.46	9.1	$198.79	$2,184.46	$198.79	-	5	$10,194.15
Medical Appts.	2011 Ford E 350	**	2011	$34,833.50	$3,483.35	9.1	$316.98	$3,483.35	$316.98	-	5	$3,483.35
Medical Appts.	01 Light Duty Ford Eldora	*	2002	$44,353.00	$0.00		$0.00	$0.00	$0.00	-	5	$44,353.00
Medical Appts.	02 Mini Van Chevy Ventur	*	2002	$33,545.00	$0.00		$0.00	$0.00	$0.00		5	$33,545.00
Medical Appts.	03 Ford Eldorado	*	2003	$54,404.53	$0.00		$0.00	$0.00	$0.00		5	$54,404.53
Medical Appts.	2008 Chevy Braun	*	2007	$32,564.00	$6,512.80	8	$521.02	$3,799.13	$521.02		5	$23,337.53
Medical Appts.	2008 Eldorado Aerotech	*	2008	$52,873.00	$10,574.60	8	$845.97	$1,762.43	$845.97		5	$33,483.23
Medical Appts.	Ford Eldorado Aerotech	*	2009	$57,819.00	$11,563.80	8	$925.10	$5,300.08	$925.10		5	$16,863.88
				$366,208.53	$36,669.97		$3,021.80	$18,880.41	$3,021.80			$264,559.50

*
**

* Owned by Park Lawn School Depreciation $2,292.10

** Owned by Park Lawn Assoc. Depreciation $729.71

$3,021.80

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

	Program %	Cost	Program Cost	Program %	Accum. Deprec	Program Accum Deprec.
Owned by Park Lawn School	0.08	$275,558.53	$22,044.68	0.08	$205,987.17	$16,478.97
Owned by Park Lawn Assoc.	0.091	$90,650.00	$8,249.15	0.091	$58,572.33	$5,330.08
			$30,293.83			$21,809.06

XII. C. Vehicle Rental

	1 Use	2 Make, Model & Year	3 Monthly Lease Pymt	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
	Activities	2005 Free Ford	$295.00	0.241	71.10	$853.14
	Activities	2005 Ford Taurus	$300.00	0.241	72.30	$867.60
	Activities	96 Mercury Sable Station Wagon	$130.00	0.241	31.33	$375.96
	Activities	1998 Econo Van	$130.00	0.241	31.33	$375.96
	Activities	2011 Ford E 350	$518.00	0.241	124.579	$1,494.95
21	Totals		$1,373.00		330.63	$3,967.61

Explanation Notes:

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

Line 7 Column 2

Cable TV	762
Pest Control	$1,257
Plant Security	$1,210
	$3,229

Line 15 Column 1

Staff Trainer	$8,524
QMRP	$114,120
Res. Serv. Coor.	$25,297
Hab. Aides	$664,057
Dietary-Laundry Manager	$31,100
Psychiatrist	$9,928
	$853,026

Schedule V. Page 4

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

Line 36 Column 5 Unallowed Capital Acquisition Grant Depreciation identified

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

Building Depreciation	$145,189	
Vehicle Depreciation	$729.00	
Equipment Depreciation	$24,275.00	
		$170,193.00

Line 35 Column 8 Community Leased equipment: Copier $7,090, PACE $3,886

Schedule VII. Part B

Park Lawn Association, Inc.			
Building Rental not allowed			($131,048)
Equipment Rental not allowed			($4,993)
Allowable Building Interest		$140,312	
Allowable Vehicle Interest $735 X 8%		$59	
			$140,371
Depreciation Allowed			
Building	$145,189		
Vehicle Depreciation	$729		
Equipment	$24,275		
Total Depreciation Allowed *	$170,193		$170,193

* Based on Public Aid allowable Depreciation Book Depreciation on building is $2,400 higher than Public Aid allowable depreciation

Total Related Party Adjustment Detailed on Page 5A line 49 $174,523.00

Schedule VIII. Part B

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

Schedule IX Interest Expense Column 10

Hinsdale Bank & Ford Credit	This programs share of vehicle interest $735 X 8%	$59.00
Founders Bank	This programs mortgage interest allowed from related party	$140,312.00

Schedule XI. Part D

Line 46 Column 5 Includes only the program portion of depreciation costs on vehicles.
Due to the number of Participants transported in all Park Lawn Programs, Park Lawn is unable to
assign one vehicle to any one location, so costs are assigned on a percentage of use basis.
The vehicles with 8% usage are almost all wheel chair accessible and must be used when transporting wheel chair bound participants.

Schedule XII Part C Page 14

Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location,
so costs are assigned on a percentage of use basis. These vehicle lease costs are only program portion and are for activities.
A detailed schedule of proration is on Page 26.

Schedule XIII. B Page 15

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

Schedule XVIII. Page 19

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

Schdeule XVIII. Page 20 Line 33	Hrs. Worked	Hrs. Paid & Accrued	
Drivers	1665	1933	$19,172
Dietary- Laundry Manager	2014	2114	$31,100
Trainer	441	510	$8,524
	4120	4557	$58,796

Schedule XX. Page 23

Question 15 No Employee meals are served