

		FOR BHF USE				

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**2013  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2013)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0036103</u></p> <p><b>Facility Name:</b> <u>Garden Center Services</u></p> <p><b>Address:</b> <u>8345 S Austin Ave</u> <u>Burbank</u> <u>60459</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>( 773 ) 941-4151</u> Fax # <u>( 773 ) 941-4591</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>05/15/1990</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input checked="" type="checkbox"/> <b>VOLUNTARY,NON-PROFIT</b></td> <td style="width: 33%;"><input type="checkbox"/> <b>PROPRIETARY</b></td> <td style="width: 33%;"><input type="checkbox"/> <b>GOVERNMENTAL</b></td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 c (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact: Name:</b> <u>Ralph Storino, Dir. of Fiscal Mgmt</u> <b>Telephone Number:</b> <u>( 773 ) 941-4151 ext. 216</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> <b>VOLUNTARY,NON-PROFIT</b>	<input type="checkbox"/> <b>PROPRIETARY</b>	<input type="checkbox"/> <b>GOVERNMENTAL</b>	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 c (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2012</u> to <u>06/30/2013</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Gerard S. Beagles</u></td> </tr> <tr> <td></td> <td>(Title) <u>Executive Director</u></td> </tr> <tr> <td style="vertical-align: top;"><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>( ) ( )</u> Fax # <u>( ) ( )</u></td> </tr> </table> <p align="right">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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>Gerard S. Beagles</u>		(Title) <u>Executive Director</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( ) ( )</u> Fax # <u>( ) ( )</u>
<input checked="" type="checkbox"/> <b>VOLUNTARY,NON-PROFIT</b>	<input type="checkbox"/> <b>PROPRIETARY</b>	<input type="checkbox"/> <b>GOVERNMENTAL</b>																																					
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	(Telephone) <u>( ) ( )</u> Fax # <u>( ) ( )</u>																																						

Facility Name & ID Number Garden Center Services

# 0036103 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,044			5,044	13
14	TOTALS	5,044			5,044	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.13%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 05/15/1990

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

YES  Date 05/15/1990 NO

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

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 07/12-06/13 Fiscal Year: 07/12-06/13

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

Facility Name &amp; ID Number

Garden Center Services

# 0036103

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	36,847	620	3,388	40,855		40,855	40,855			1
2	Food Purchase		42,328		42,328		42,328	42,328			2
3	Housekeeping	11,015	2,234		13,249		13,249	13,249			3
4	Laundry	3,672	1,489		5,161		5,161	5,161			4
5	Heat and Other Utilities			14,282	14,282		14,282	14,282			5
6	Maintenance	9,883	14,375	1,080	25,338		25,338	25,338			6
7	Other (specify):* Waste/PersonalAll			16,864	16,864		16,864	16,864			7
8	<b>TOTAL General Services</b>	61,417	61,046	35,614	158,077		158,077	158,077			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,154	1,154		1,154	1,154			9
10	Nursing and Medical Records	240,696	9,359	806	250,861		250,861	250,861			10
10a	Therapy										10a
11	Activities		2,878		2,878		2,878	2,878			11
12	Social Services	42,597	1,771		44,368		44,368	44,368			12
13	CNA Training			1,623	1,623		1,623	1,623			13
14	Program Transportation		4,153		4,153		4,153	4,153			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	283,293	18,161	3,583	305,037		305,037	305,037			16
	<b>C. General Administration</b>										
17	Administrative	33,881			33,881		33,881	33,881			17
18	Directors Fees										18
19	Professional Services			9,249	9,249		9,249	9,249			19
20	Dues, Fees, Subscriptions & Promotions			4,218	4,218		4,218	4,218			20
21	Clerical & General Office Expenses	19,359	2,601	14,096	36,056		36,056	36,056			21
22	Employee Benefits & Payroll Taxes			61,947	61,947		61,947	61,947			22
23	Inservice Training & Education										23
24	Travel and Seminar			551	551		551	551			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			10,126	10,126		10,126	10,126			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	53,240	2,601	100,187	156,028		156,028	156,028			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	397,950	81,808	139,384	619,142		619,142	619,142			29

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

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

Facility Name &amp; ID Number

Garden Center Services

#0036103

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			20,054	20,054		20,054	20,054				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,463	26,463		26,463	26,463				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			46,517	46,517		46,517	46,517				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,952	46,952		46,952	46,952				42
43	Other (specify):* <b>Workshop Costs</b>			166,958	166,958		166,958	166,958				43
44	<b>TOTAL Special Cost Centers</b>			213,910	213,910		213,910	213,910				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	397,950	81,808	399,811	879,569		879,569	879,569				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 Garden Center Services

# 0036103

Report Period Beginning: 07/01/2012

Ending: 06/30/2013

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

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

BHF USE ONLY						
48		49		50		51
						52

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

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

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

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

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

Garden Center Services

ID# 0036103

Report Period Beginning: 07/01/2012

Ending: 06/30/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Garden Center Services# 0036103

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

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



## STATE OF ILLINOIS

Facility Name & ID Number Garden Center Services# 0036103

Report Period Beginning:

07/01/2012 Ending:

Summary B

06/30/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>45</b>

**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
N/A						

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	<b>Total</b>			\$			\$	\$ *	14

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

Facility Name & ID Number

Garden Center Services

# 0036103

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Garden Center Services

# 0036103

Report Period Beginning: 07/01/2012

Ending:

06/30/2013

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								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 Garden Center Services

# 0036103

Report Period Beginning:

07/01/2012

Ending: 6/30/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Garden Center Services  
 Street Address 8333 S. Austin Ave  
 City / State / Zip Code Burbank, IL. 60459  
 Phone Number ( 773 ) 941-4151  
 Fax Number ( 773 ) 941-4591

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17-1	Administrative Salary	Full time Equivalents		\$ 325,661	\$ 33,881		\$	1	
2									2	
3		There were 111.50 FTE staff budgeted in Garden Center programming of which 11.60 FTE worked in the ICF. Each Program takes a percentage of Administrative salaries based on the FTE's within a program divided by the total number of FTE's of all agency programming								3
4		This programs share was 10.40%								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				\$ 325,661	\$ 33,881		\$	25	

Facility Name & ID Number

Garden Center Services

# 0036103

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	The Private Bank		X	ICF/DD	\$2,917.00	06/20/13	\$ 370,159	\$ 370,159	06/20/2018	0.0488	\$ 26,463	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$2,917.00		\$ 370,159	\$ 370,159			\$ 26,463	9					
	<b>B. Non-Facility Related*</b>																
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 370,159	\$ 370,159			\$ 26,463	15					

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

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

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

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

**B. Real Estate Taxes**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>																																				
1. Real Estate Tax accrual used on 2012 report.		\$ <u>Exempt</u>	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.)		\$ <u>Exempt</u>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>#VALUE!</u>	3																																	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <u>#VALUE!</u>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2008</td><td>_____</td><td>8</td></tr> <tr><td>2009</td><td>_____</td><td>9</td></tr> <tr><td>2010</td><td>_____</td><td>10</td></tr> <tr><td>2011</td><td>_____</td><td>11</td></tr> <tr><td>2012</td><td>_____</td><td>12</td></tr> </table>	2008	_____	8	2009	_____	9	2010	_____	10	2011	_____	11	2012	_____	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2012</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2012	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2008	_____	8																																		
2009	_____	9																																		
2010	_____	10																																		
2011	_____	11																																		
2012	_____	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2012	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	

**NOTES:**

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

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Garden Center Services COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036103

CONTACT PERSON REGARDING THIS REPORT Ralph Storino, Director of Fiscal Management

TELEPHONE ( 773 ) 941-4151 FAX #: ( 773 ) 941-4591

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>19-32-418-005-0000</u>	<u>8345 S. Austin Ave. Burbank, IL.</u>	\$ <u>Tax Exempt</u>	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**



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

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

C. **Tax Bills**

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

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 5,335 B. General Construction Type: Exterior Brick Frame Ordinary Number of Stories One

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Building</u>	<u>10,000</u>	<u>1990</u>	<u>\$ 94,000</u>	1
2					2
3	<b>TOTALS</b>	<b>10,000</b>		<b>\$ 94,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	15	1990	1990	\$ 510,755	\$ 16,214	31.5	\$ 16,214		\$ 374,936
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Building		1993	2,912	92	31.5	92		1,829
10	Hot Water Heater		1996	6,272	199	31.5	199		4,803
11	Lot Repaving		1999	20,000		10			20,000
12	Kitchen cabinetry, flooring, lighting		2010	14,350	957	15	957		2,871
13	Kitchen Door		2010	5,000	333	15	333		999
14	Kitchen Electric upgrade		2010	450	30	15	30		90
15	Kitchen Plumbing		2010	540	36	15	36		108
16	Building Roof		2011	21,900	1,460	15	1,460		3,650
17	ADA Bathroom Shower		2011	5,928	593	10	593		1,482
18	Three Exterior Doors		2012	4,201	140	15	140		140
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 592,308	\$ 20,054		\$ 20,054	\$	\$ 410,908	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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	ICF/DD	Dodge Caravan	2006	\$ 18,920	\$	\$	\$	5	\$ 18,920	76
77										77
78										78
79										79
80	TOTALS			\$ 18,920	\$	\$	\$		\$ 18,920	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)	\$ 705,228	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,054	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,054	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)	\$ 429,828	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.

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

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. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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

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

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

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>120</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments			1,623	1,623
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$ 1,623	\$ 1,623
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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>10</b>

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		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 prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$		\$	\$		\$	14	

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



Facility Name & ID Number Garden Center Services# 0036103Report Period Beginning: 07/01/2012Ending: 06/30/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2013 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 820,590	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>6,000</u> )	755,750		3
4	Supply Inventory (priced at )	77,138		4
5	Short-Term Investments	172,071		5
6	Prepaid Insurance	29,286		6
7	Other Prepaid Expenses	3,681		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposits</u>	12,829		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,871,345	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	472,875		13
14	Buildings, at Historical Cost	3,487,612		14
15	Leasehold Improvements, at Historical Cost	1,278,923		15
16	Equipment, at Historical Cost	727,594		16
17	Accumulated Depreciation (book methods)	(2,018,982)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,948,022	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,819,367	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 93,433	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,339,680		29
30	Accrued Salaries Payable	88,270		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,671		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,881		32
33	Accrued Interest Payable			33
34	Deferred Compensation	195,006		34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Deferred Revenue</u>	22,985		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,767,926	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,103,710		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,103,710	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,871,636	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,947,731	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,819,367	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	1,843	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 1,843	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,843	24 *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 714,256	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 714,256	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,271	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 4,271	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	126	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 126	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Day Training</u>	162,759	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 162,759	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 881,412	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	158,077	31
32	Health Care	305,037	32
33	General Administration	156,028	33
<b>B. Capital Expense</b>			
34	Ownership	46,517	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	46,952	36
<b>D. Other Expenses (specify):</b>			
37	<u>Workshop Costs</u>	166,958	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 879,569	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,843	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,843	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 542,636	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Social Security</u>	171,620	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 714,256	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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 Garden Center Services

# 0036103

Report Period Beginning:

07/01/2012

Ending:

06/30/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	928	1,016	\$ 35,130	\$ 34.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,075	2,157	29,896	13.86	14
15	Cook Helpers/Assistants	648	675	6,951	10.30	15
16	Dishwashers					16
17	Maintenance Workers	683	715	9,883	13.82	17
18	Housekeepers	948	1,049	11,015	10.50	18
19	Laundry	321	362	3,672	10.14	19
20	Administrator	226	264	15,230	57.69	20
21	Assistant Administrator	191	223	8,798	39.45	21
22	Other Administrative	294	342	9,853	28.81	22
23	Office Manager	369	384	9,208	23.98	23
24	Clerical	596	662	10,151	15.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,189	2,423	42,597	17.58	28
29	Resident Services Coordinator	610	689	16,426	23.84	29
30	Habilitation Aides (DD Homes)	16,839	17,506	186,090	10.63	30
31	Medical Records	242	247	3,050	12.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	27,159	28,714	\$ 397,950 *	\$ 13.86	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	68	\$ 3,388	1, Col. 3	35
36	Medical Director	8	1,154	9, Col. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	5	184	10, Col. 3	39
40	Physical Therapy Consultant	4	168	10, Col. 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	2	454	10, Col. 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	87	\$ 5,348		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gerard Beagles	Executive Director	0	\$ 15,230	Workers' Compensation Insurance	\$ 15,718	IDPH License Fee	\$	
Ralph Storino	Dir. of Fiscal Mgmt	0	2,761	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
Sheila Harris	Controller	0	2,333	FICA Taxes	28,544	Health Care Worker Background Check	1,004	
John Kincinas	Info Technology	0	4,759	Employee Health Insurance	15,156	(Indicate # of checks performed)		
Cindy Haworth	Dir. of Operations	0	8,798	Employee Meals		Patient Background Checks	15	
				Illinois Municipal Retirement Fund (IMRF)*		Professional Membership	2,311	
				Disability Insurance	2,529	Physicals	774	
						Reference Materials	129	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 33,881					
<b>B. Administrative - Other</b>								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 61,947	
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 4,218	
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Ciarlette & Robbins, LLP	Auditor		\$ 1,981			\$	Out-of-State Travel	\$
James Absher	IT Consultant		219					
Mahoney, Crowe and Goldrick	Attorney		665					
Paycom	Payroll Service		4,766				In-State Travel	551
ADP	Retirement Trust Fund		1,618				See Page 26	
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 9,249				\$ 551	

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Garden Center Services

# 0036103

Report Period Beginning: 07/01/2012 Ending: 06/30/2013

## 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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (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. \$ 46,952  
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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? N/A  
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?  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ciarlette & Robbins, LLP (Audit currently in progress)
- (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.

**2013 State of Illinois  
Department of Healthcare and Family Services  
Financial and Statistical Report for  
Long-Term Care Facilities**

**Garden Center Services**

**8345 S. Austin Avenue    Burbank, Illinois 60459**

**Facility ID Number :      0036103**

**Attachment for Page 4, Line 43 Column 3**

Workshop Costs:

Salaries	\$	102,478
Payroll Benefits		19,461
Consultants and Related		7,419
Consumables		6,934
Occupancy		18,499
Transportation		8,357
Miscellaneous		3,810
	<u>\$</u>	<u>166,958</u>



**2013 State of Illinois  
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**Garden Center Services**

8345 S. Austin Avenue Burbank, Illinois 60459

Facility ID Number : 0036103

**Garden Center Services Board of Directors**

<u>Name</u>	<u>Title</u>	<u>Provides Services to ICF Facility?</u>	<u>Type ?</u>	<u>Transactions with ICF Facility?</u>	<u>Type?</u>	<u>Ownership in business transacting with ICF?</u>	<u>Type?</u>
Patrick Ballis	Treasurer	No	N/A	No	N/A	No	N/A
Annemarie Caufield	Secretary	No	N/A	No	N/A	No	N/A
Doug Combs	2nd Vice President	No	N/A	No	N/A	No	N/A
Sharon Duncan	Board Member	No	N/A	No	N/A	No	N/A
John Kunkes	Board Member	No	N/A	No	N/A	No	N/A
Scott Hardek	Board Member	No	N/A	No	N/A	No	N/A
Sean O'Shea	Board Member	No	N/A	No	N/A	No	N/A
Linda Sherwood	Board Member	No	N/A	No	N/A	No	N/A
Dan Wenzler	President	No	N/A	No	N/A	No	N/A
Jenny Wojcik	1st Vice President	No	N/A	No	N/A	No	N/A

**2013 State of Illinois  
 Department of Healthcare and Family Services  
 Financial and Statistical Report for  
 Long-Term Care Facilities**

**Garden Center Services**

8345 S. Austin Avenue Burbank, Illinois 60459

Facility ID Number 0036103

**Detail for Page 3, Line 7, Column 3**

**General Service- Other**

Waste	\$ 3,138
Security System	4,576
Consumer Personal Allowances	9,150
	<u>\$ 16,864</u>

**Detail for Page 3, Line 24, Column 3**

**General Administration- In-State Travel**

<u>Employee Name</u>	<u>Title</u>	<u>Function</u>	<u>Cost</u>
Gerard Beagles	Executive Director	Administrator	\$ 333
Pam Kennedy	Nurse	Nursing	\$ 120
Sheryl Kincinas	Supervisor	Nursing	\$ 40
Kathy Proffitt	Case Manager	Social Services	\$ 58
		Total	<u>\$ 551</u>