FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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.

I. IDPH License ID Number: 0035527

Facility Name: Park Lawn Home

Address: 12615 S Kostner Ave (Number) Alsip (City) 60803 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code

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 7/1/14 to 6/30/15 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) 10-27-15 (Date)
(Type or Print Name) Steve Manning
(Title) Executive Director

Paid Preparer

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,185			5,185	13
14	TOTALS	5,185			5,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.70%

D. How many bed-hold days during this year were paid by the Department?
163 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/31/91

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [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: 6-30-15 Fiscal Year: 6-30-15

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	23,784	1,327	1,440	26,551		26,551		26,551			1
2	Food Purchase		60,846		60,846		60,846		60,846			2
3	Housekeeping	13,585	1,600		15,185		15,185		15,185			3
4	Laundry		958		958		958		958			4
5	Heat and Other Utilities			1,220	1,220		1,220	10,520	11,740			5
6	Maintenance	10,580	228	5,609	16,417		16,417	35,692	52,109			6
7	Other (specify):*		1,974		1,974		1,974		1,974			7
8	**TOTAL General Services**	47,949	66,933	8,269	123,151		123,151	46,212	169,363			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	16,017	13,540	6,000	35,557		35,557		35,557			10
10a	Therapy			1,898	1,898		1,898		1,898			10a
11	Activities		2,155		2,155		2,155		2,155			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation		2,893	1,366	4,259		4,259		4,259			14
15	Other (specify):*	216,079			216,079		216,079		216,079			15
16	**TOTAL Health Care and Programs**	232,096	18,588	12,864	263,548		263,548		263,548			16
	C. General Administration											
17	Administrative	10,082			10,082		10,082	25,631	35,713			17
18	Directors Fees											18
19	Professional Services			9,455	9,455		9,455		9,455			19
20	Dues, Fees, Subscriptions & Promotions			2,769	2,769		2,769		2,769			20
21	Clerical & General Office Expenses	65,581	4,631		70,212		70,212		70,212			21
22	Employee Benefits & Payroll Taxes			93,430	93,430		93,430	(490)	92,940			22
23	Inservice Training & Education			1,541	1,541		1,541		1,541			23
24	Travel and Seminar			16	16		16		16			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,007	1,007		1,007	10,602	11,609			26
27	Other (specify):*											27
28	**TOTAL General Administration**	75,663	4,631	108,218	188,512		188,512	35,743	224,255			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	355,708	90,152	129,351	575,211		575,211	81,955	657,166			29

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

Facility Name & ID Number Park Lawn Home #0035527 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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			1,472	1,472		1,472	40,039	41,511			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,055	3,055		3,055	48,884	51,939			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			58,611	58,611		58,611		58,611			34
35	Rent-Equipment & Vehicles			7,288	7,288		7,288		7,288			35
36	Other (specify):*											36
37	**TOTAL Ownership**			70,426	70,426		70,426	88,923	159,349			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			37,932	37,932		37,932		37,932			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			37,932	37,932		37,932		37,932			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	355,708	90,152	237,709	683,569		683,569	170,878	854,447			45

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	(490)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (490)		$	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	171,368	5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 171,368		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 170,878		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Park Lawn Home

ID# 0035527

Report Period Beginning: 7/1/14

Ending: 6/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Depreciation from Related Party PLH	$ 39,588	30	1
2	Allowable Interest from Related Party PLH	48,884	32	2
3	Allowable Party Depreciation PLA	451	30	3
4	Allowable Related Party Utilities	10,520	5	4
5	Allowable Related Party Maintenance	35,692	6	5
6	Allowable Related Party Administrative	25,631	17	6
7	Allowable Related Party Insurance	10,602	26	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	171,368		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	10,520	0	0	0	0	0	0	0	0	0	0	10,520	5
6	Maintenance	35,692	0	0	0	0	0	0	0	0	0	0	35,692	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	46,212	0	0	0	0	0	0	0	0	0	0	46,212	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	25,631	0	0	0	0	0	0	0	0	0	0	25,631	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	(490)	0	0	0	0	0	0	0	0	0	0	(490)	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	10,602	0	0	0	0	0	0	0	0	0	0	10,602	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	35,743	0	0	0	0	0	0	0	0	0	0	35,743	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	81,955	0	0	0	0	0	0	0	0	0	0	81,955	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	40,039	0	0	0	0	0	0	0	0	0	0	40,039	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	48,884	0	0	0	0	0	0	0	0	0	0	48,884	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	88,923	0	0	0	0	0	0	0	0	0	0	88,923	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)**	170,878	0	0	0	0	0	0	0	0	0	0	170,878	45

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 Organizatic
				Park Lawn Home, Inc.	Alsip	

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Park Lawn Assocation, See Explanation on page 5A and in notes		$	$	1
2	V								2
3	V				Park Lawn Home, Inc. See Explanation on page 5A and in notes				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	Bonnie Price	BOD						2
3	Maureen Reilly	BOD						3
4	Chuck DiNolofo	BOD						4
5	James Himmel	BOD						5
6	Rob Barnes	BOD						6
7	Marilyn Wnuk	BOD						7
8	Tom Olofsson	BOD						8
9	Chuck Jenrich	BOD						9
10	Steve Janiszewski	BOD						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

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

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

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

Facility Name & ID Number Park Lawn Home # 0035527 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

Exempt

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035527

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Exempt	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	15			1991	$ 676,975	$ 27,079	25	$ 27,079	$	$ 636,995	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1995	18,306	732	25	732		14,705	9
10	Door East Side			2001	950	63	15	63		886	10
11	Bathroom Floor Tile			2001	625	42	15	42		609	11
12	Vinyl Flooring			2002	15,657		10			15,657	12
13	Storm Sewer			2002	3,780		10			3,780	13
14	4 Thermostats			2007	1,965	98	20	98		826	14
15	Sidewalks, Handrail, & Door			2007	7,815	391	20	391		3,159	15
16	8 Toilets			2009	3,573	179	20	179		1,088	16
17	Galv Frames Shower			2009	1,833	91	20	91		549	17
18	Door Hardware			2009	3,370	168	20	168		1,022	18
19	Door Hardware Installation			2009	1,140	57	20	57		344	19
20	Wall Corner Guards			2009	1,050	70	15	70		414	20
21	Washroom Wall & Floor Tile			2009	6,880	459	15	459		2,676	21
22	Additional Door Hardware			2009	732	37	20	37		214	22
23	4 Vapor Proof lights Bath Area			2010	1,075	108	10	108		583	23
24	Fence Repair			2010	1,260	126	10	126		620	24
25	Roof			2011	16,805	1,120	15	1,120		4,108	25
26	HVAC 4 Units			2012	34,035	2,269	15	2,269		5,862	26
27	Paint in copier room			2014	975	49	20	49		53	27
28	Drywall in Copier Room			2014	650	33	20	33		36	28
29	Framing for Copier Room			2014	450	23	20	23		25	29
30	Door to Copier Room			2014	700	35	20	35		38	30
31	Permits & License			2014	365	18	20	18		19	31
32	Painting Kitchen & Dining Area			2014	2,150	108	20	108		108	32
33	Flooring in Kitchen & Dining Area			2014	4,275	214	20	214		214	33
34	Electrical in Kitchen & Dining Area			2014	2,157	108	20	108		108	34
35	Plumbing in Kitchen			2014	1,565	78	20	78		78	35
36	Counter Tops in Kitchen			2014	2,250	113	20	113		113	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	Cabinets in Kitchen	2014	$ 3,890	$ 195	20	$ 195	$	$ 195	37
38	Hutch Unit in Dining Area	2014	3,250	163	20	163		163	38
39	Preparation & Demolition in Kitchen & Dining Areas	2014	6,495	325	20	325		325	39
40	Repave and Strip Parking Lot	2014	33,342	1,111	20	1,111		1,111	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)		$ 860,340	$ 35,659		$ 35,659	$	$ 696,680	70

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	$ 35,640	$ 3,929	$ 3,929	$	various	$ 14,130	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	22,224					22,224	73
74								74
75	TOTALS	$ 57,864	$ 3,929	$ 3,929	$		$ 36,354	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 noted page 25. A small % of a few vehicles			$ 17,757	$ 1,923	$ 1,923	$	5	$ 13,466	76
77										77
78										78
79										79
80	TOTALS			$ 17,757	$ 1,923	$ 1,923	$		$ 13,466	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)	$ 1,013,003	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,511	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 41,511	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)	$ 746,500	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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 7-1-14
    Ending 6-30-15

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

	Fiscal Year Ending	Annual Rent
12.	6/30/2016	$
13.	6/30/2017	$
14.	6/30/2018	$

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: $ 6,606 Description: PACE $2276 Copier $4330
    (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.		$ 57.00	$ 682	17
18					18
19					19
20					20
21	TOTAL		$ 57.00	$ 682	21

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15 (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	$ 284,300	$	1
2	Cash-Patient Deposits	95,012		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,213		6
7	Other Prepaid Expenses	24,854		7
8	Accounts Receivable (owners or related parties)	811,895		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,312,274	$	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	564,908		16
17	Accumulated Depreciation (book methods)	(456,879)		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)**	$ 108,029	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,420,303	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 220,554	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,911		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	399,146		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,844		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	Client Reserves	1,649		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 724,104	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	579,956		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)**	$ 579,956	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,304,060	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 116,243	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,420,303	$	48

***(See instructions.)**

Facility Name & ID Number Park Lawn Home **#** 0035527 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 603,710	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 603,710	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,214	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)**	$ 4,214	23
	D. Non-Operating Revenue		
24	Contributions	76,124	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 76,124	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)**	$ 684,048	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	123,151	31
32	Health Care	263,548	32
33	General Administration	188,512	33
	B. Capital Expense		
34	Ownership	70,426	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,932	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 683,569	40
41	**Income before Income Taxes (line 30 minus line 40)****	479	41
42	**Income Taxes**	479	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Notes p 29 **If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	641	767	16,017	20.88	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	1,935	2,217	23,784	10.73	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	597	644	10,580	16.43	17
18	Housekeepers	1,015	1,415	13,585	9.60	18
19	Laundry					19
20	Administrator	136	179	10,082	56.32	20
21	Assistant Administrator					21
22	Other Administrative	773	926	24,136	26.06	22
23	Office Manager	1,656	2,080	38,809	18.66	23
24	Clerical	162	202	2,636	13.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	11,761	16,858	177,403	10.52	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See notes page 27	2,667	3,772	38,676	10.25	33
34	TOTAL (lines 1 - 33)	21,343	29,060	$ 355,708 *	$ 12.24	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	48	$ 1,440	1-3	35
36	Medical Director	29	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	35	1,898	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	24	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	136	$ 12,938		49

C. CONTRACT NURSES

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James R. Weise	Executive Director		$ 9,445
Steve Manning	Executive Director		637
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 10,082

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Wessels Sherman	Legal	$ 29
Kronos	Computer Payroll	38
Paycor	Computer Payroll	2,847
Comcast	Date Processing	1,135
Communuty Service Partners	Date Processing	4,555
Himmel	Legal	5
Cocalas, Westberg & Mommsen	Audit	846
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 9,455

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,047
Unemployment Compensation Insurance	1,777
FICA Taxes	26,080
Employee Health Insurance	55,439
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer Match	597
Man Ben $490 not included in total	
TOTAL (agree to Schedule V, line 22, col.8)	$ 92,940

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	159
Health Care Worker Background Check	178
(Indicate # of checks performed 6)	
Patient Background Checks 0	0
License Fees	145
Membership Fees	1,736
Subscriptions	551
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,769

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
ARC of IL Leadership Conference	16
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16

**See instructions.

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Park Lawn Home** **#** **0035527** **Report Period Beginning:** **7/1/14** **Ending:** **6/30/15**

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. $ **1,778** 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. $ **37,932**
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. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A Personal Use not permitted**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Cocalas, Westberg & Mommsen**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes see page 29**
Attach invoices and a summary of services for all architect and appraisal fees.

Park Lawn Home #0035527 Report Period Beginning: 7-1-14 Ending: 6-30-15

Related Party Adjustment

Park Lawn Home

Lease Adjustment Management Benefits P/R & In Kind	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL
ADJUSTMENT EXPLANATION 2014/2015 FY								
Total Lease	671769	87698	149376	17540	3531	197731	65899	149994
LESS: Community Lease	100349	21910	41952	9017	396	6591	6606 6606	13877
Related Organization	571420	65788	107424	8523	3135	191140	59293	136117
Interest & Depreciation Related Organization	547975	18974	87569	7116	2663	111946	88896	230811
Adjustment	23445	46814	19855	1407	472	79194	-29603	-94694
Adjust Related Organization	547975	18974	87569	7116	2663	111946	88896	230811
Community Lease	100349	21910	41952	9017	396	6591	6606	13877
Grand Total Allowable Lease	648324	40884	129521	16133	3059	118537	95502	244688
Other Adjustments								
Management Benefits	-6367	-856	-1580	-278	-190	-1312	-490	-1661
Public Relations	5659	188	5471	0	0	0	0	0
In Kind	0	0	0	0	0	0	0	0

	PLA	PLH
Total Interest	137109	48884
Total Depreciation	339273	39589
	476382	88473
PLH	88473	
	564855	
Fundraising	-16880	

PLA Depreciation
Bldg. Depreciation 265672
Equipment Depreciation 73601
339273

Mortgage Interest
Vehicle Interest

547975

135831
1278
137109

D. Vehicle Depreciation

1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Program % Depre.	6 Straight Line Depr.	Program % Straight Line Dep.	7 Adjustments	8 Life in Years
Activities	98 Econo Van	**	2005	$7,333.50	$0.00	6.48	$0.00	$0.00	$0.00		5
Activities	05 Ford Free	**	2006	$17,632.33	$0.00	6.48	$0.00	$0.00	$0.00		5
Activities	96 Merucry Sable	**	1996	$19,929.00	$0.00	6.48	$0.00	$0.00	$0.00		5
Activities	11 Ford E350	**	2011	$34,833.00	$6,966.70	6.48	$451.44	$6,966.70	$451.44		5
Activities	03 Ford Eldorado	*	2003	$54,404.53	$0.00	3.00	$0.00	$0.00	$0.00		5
Activities	08 Chervrolet Braun	*	2007	$32,564.00	$0.00	3.00	$0.00	$0.00	$0.00		5
Activities	08 Eldorado Aerotech	*	2008	$52,873.00	$0.00	3.00	$0.00	$0.00	$0.00		5
Activities	09 Ford Eldorado Aerotech	*	2010	$57,819.00	$6,263.72	3.00	$187.91	$6,263.72	$187.91		5
Activities	11 Ford E450 SuperDuty	*	2010	$57,746.00	$11,549.20	3.00	$346.48	$11,549.20	$346.48		5
Activities	12 Ford ElDorado 220	*	2012	$58,337.00	$11,667.40	3.00	$350.02	$11,667.40	$350.02		5
Activities	2013 Dodge Grand Caravan	*	2013	$36,672.00	$7,334.40	3.00	$220.03	$7,334.40	$220.03		5
Activities	2005 Ford ElDorado Me Duty	*	2014	$14,850.00	$2,722.50	3.00	$81.68	$2,722.50	$81.68		5
Activities	2014 Fors Starcraft	*	2014	$54,435.00	$9,526.13	3.00	$285.78	$9,526.13	$285.78		5
				$499,428.36	$56,030.05		$1,923.34	$56,030.05	$1,923.34		
									$1,471.90		

* Owned by Park Lawn School Depreciation	$1,471.90
** Owned by Park Lawn Association Depreciation	$451.44
	1923.34

	Program Percentage	Cost	Total Program Cost	Program Percentage	Accumulated Depreciation	Total Program Accum Depreciation
* Owned by Park Lawn School Depreciation	0.03	$419,700.53	$12,591.02	0.03	$314,273.78	$9,428.21
** Owned by Park Lawn Association Depreciation	0.0648	$79,727.83	$5,166.36	0.0648	$62,311.53	$4,037.79
		$499,428.36	$17,757.38		$376,585.31	$13,466.00

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn in unable to assign any vehicle to any one location, costs are assigned on a percentage of use basis. The vehicles with the 3.00% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

9 Accumulated Depreciation
$7,333.50
$17,632.33
$19,929.00
$17,416.70
$54,404.53
$32,564.00
$52,873.00
$57,819.00
$51,971.40
$39,863.62
$12,529.60
$2,722.50
$9,526.13
$376,585.31

XII. C. Vehicle Rental

	1 Use	2 e, Model & Year	3 Monthly Lease Pymt.	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
17	Activities	05 Ford Free	$277.00	0.0648	$17.95	$215.40
	Activities	98 Econo Van	$60.00	0.0648	$3.89	$46.66
	Activities	96 Mercury Sable	$67.00	0.0648	$4.34	$52.10
	Activities	11 Ford E350	$473.00	0.0648	$30.65	$367.80
21	Totals		$877.00		$56.83	$681.96

Explanation Notes:

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

Line 7 column 2

Cable	$1,937
Pest Control	$13
Plant Security	$24
	$1,974

Line 15 Column 1

Staff Trainer	$3,245
Facility Services Coor	$25,576
Hab Aides	$177,403
Drivers	$9,855
	$216,079

Schedule V. Page 3 & 4

Line 5 Column 7	Allowable Related Party Costs for Utilities	$10,520
Line 6 Column 7	Allowable Related Party Costs for Maintenance	$35,692
Line 17 Column 7	Allowable Related Party Costs for Administrative	$25,631
Line 26 Column 7	Allowable Related Party Costs for Insurance	$10,602
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	$39,588
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLA	$451
Line 32 Column 7	Allowable Related Party Costs for Interest PLH	$48,884
		$171,368

Total Related Party Costs

Line 34 Column 4 Includes:

Office for Park Lawn School Program	$8,026
Portion of Rent not in HUD Payments Park Lawn School costs	$48,930
Equipment from Park Lawn Association	$1,656
	$58,612

Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	$682
Equipment Rental	$4,330
Pace Vehicle Rental	$2,276
	$7,288

Schedule VII. Part B Page 6

Park Lawn Association, Inc.

Depreciation of Vehicles		$451

Total Park Lawn Association Costs

Park Lawn Homes, Inc.

Utilities	$10,520	
Maintenance	$35,692	
Administration	$25,631	
Taxes/Insurance	$10,602	
Interest	$48,884	
Depreciation Bldg. & Equipment	$39,588 *	
Total Park Lawn Homes Costs		$170,917

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

Total Related Party Adjustment on Page 5A Line 49 $171,368

Schedule VIII. Part B

Central Office - 10833 S. Laporte Avenue occupies 1,717 square feet for Administration and Accounting and Bookkeeping.
This is 6.96% of the total square footage of 24,693.
These costs are collected in a temporary cost center and distributed out to programs on the basis of a predetermined appropriate distribution.

Administrative salaries are distributed as follows:
1. Executive Director - % of Budget
2. Acct/Bkkp - % of Budget
3. P/R Personnel - % of Staff

Schedule XI. Part D. Page 13

Line 46 Column 5 Includes only program portion of depreciation cost on vehicles. Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.
The vehicles with the 3.00% usuage are wheel chair accessible and must be used to transport wheelchair cound clients.

Schedule XII. Part C Page 14
Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn in unable to assign any vehicle to any one location, costs are assigned on a percentage of use basis. The vehicles with the 3.00% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

Schedule XIII. Part B Page 15
Line 5 Column 4 Wages are included on page 20 line 33.

Schedule XVIII. Page 19
Does this agree with taxable income (Loss) per Federal Income Tax return? Federal Income Tax return is not completed until December of the current year.

Schedule XX. Page 23

Question 12 Allocated based on hours worked per department.

Question 15 No Employee meals are served.

Schedule XIX. Part C

Legal Fees Invoices

Name	Date	Service	Cost
Wessels Sherman	7/28/2014	Monthly Flat rate for Telephone Consultation	75
Wessels Sherman	8/28/2014	Monthly Flat rate for Telephone Consultation	75
Wessels Sherman	9/28/2014	Monthly Flat rate for Telephone Consultation	75
Wessels Sherman	10/28/2014	Monthly Flat rate for Telephone Consultation	75

Wessels Sherman	11/28/2014	Monthly Flat rate for Telephone Consultation	75
		Total for whole agency	375
		Park Lawn Home's percentage 7.69% of total	28.84
Law offuce of James I	5/31/2015	Preparation & Filing of annual report & Filing fe	65
		Total for whole agency	65
		Park Lawn Home's percentage 7.69% of total	5.00
		Grand Total Legal	33.84