

		FOR BHF USE					

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**2016**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2016)**

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>0035527</u></p> <p><b>Facility Name:</b> <u>Park Lawn Home</u></p> <p><b>Address:</b> <u>12615 S Kostner Ave</u> <u>Alsip</u> <u>60803</u>        Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708)385-1982</u> <b>Fax #</b> <u>(708) 385-8145</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9-22-82</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</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> _____</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:</b>  <b>Name:</b> <u>Janice Leise</u> <b>Telephone Number:</b> <u>(708) 425-3344 Ext. 239</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<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> _____	<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>7-1-15</u> to <u>6-30-16</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%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>Steve Manning</u> (Title) <u>Executive Director</u></td> </tr> <tr> <td></td> <td>(Date) <u>10-27-16</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Steve Manning</u> (Title) <u>Executive Director</u>		(Date) <u>10-27-16</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																													
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<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____																														

Facility Name & ID Number Park Lawn Home

# 0035527 Report Period Beginning: 7-1-15 Ending: 6-30-16

**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	5,238			5,238	13
14	TOTALS	5,238			5,238	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 95.67%

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

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

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

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

N/A

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

Yes

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

YES  NO

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

YES  NO

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

Date started 12/31/91

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

YES  Date \_\_\_\_\_ NO

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

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

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

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6-30-16 Fiscal Year: 6-30-16

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-15 Ending: 6-30-16

**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	24,095	2,243	1,820	28,158		28,158		28,158		1
2	Food Purchase		67,559		67,559		67,559		67,559		2
3	Housekeeping	14,501	1,772		16,273		16,273		16,273		3
4	Laundry		752		752		752		752		4
5	Heat and Other Utilities			1,234	1,234		1,234	10,214	11,448		5
6	Maintenance	11,315	167	7,045	18,527		18,527	32,728	51,255		6
7	Other (specify):*		2,187		2,187		2,187		2,187		7
8	<b>TOTAL General Services</b>	<b>49,911</b>	<b>74,680</b>	<b>10,099</b>	<b>134,690</b>		<b>134,690</b>	<b>42,942</b>	<b>177,632</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	21,846	15,316	6,000	43,162		43,162		43,162		10
10a	Therapy			1,870	1,870		1,870		1,870		10a
11	Activities		2,003		2,003		2,003		2,003		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation		3,637	1,662	5,299		5,299		5,299		14
15	Other (specify):*	207,175			207,175		207,175		207,175		15
16	<b>TOTAL Health Care and Programs</b>	<b>229,021</b>	<b>20,956</b>	<b>13,132</b>	<b>263,109</b>		<b>263,109</b>		<b>263,109</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	13,749			13,749		13,749	23,438	37,187		17
18	Directors Fees										18
19	Professional Services			10,601	10,601		10,601		10,601		19
20	Dues, Fees, Subscriptions & Promotions			3,673	3,673		3,673		3,673		20
21	Clerical & General Office Expenses	71,354	4,683		76,037		76,037		76,037		21
22	Employee Benefits & Payroll Taxes			100,842	100,842		100,842	(9)	100,833		22
23	Inservice Training & Education			2,495	2,495		2,495		2,495		23
24	Travel and Seminar			276	276		276		276		24
25	Other Admin. Staff Transportation			1,311	1,311		1,311		1,311		25
26	Insurance-Prop.Liab.Malpractice							10,721	10,721		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>85,103</b>	<b>4,683</b>	<b>119,198</b>	<b>208,984</b>		<b>208,984</b>	<b>34,150</b>	<b>243,134</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>364,035</b>	<b>100,319</b>	<b>142,429</b>	<b>606,783</b>		<b>606,783</b>	<b>77,092</b>	<b>683,875</b>		<b>29</b>

\*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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,586	1,586		1,586	41,304	42,890			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,729	4,729		4,729	47,886	52,615			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			59,517	59,517		59,517		59,517			34
35	Rent-Equipment & Vehicles			7,136	7,136		7,136		7,136			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			72,968	72,968		72,968	89,190	162,158			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			36,224	36,224		36,224		36,224			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			36,224	36,224		36,224		36,224			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	364,035	100,319	251,621	715,975		715,975	166,282	882,257			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:

7-1-15

Ending:

6-30-16

**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		(9) 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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$	(9)	\$	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	166,291	5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 166,291		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 166,282		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Park Lawn Home

ID# 0035527

Report Period Beginning: 7-1-15

Ending: 6-30-16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Allowable Depreciation from Related Party PLH	\$ 40,322	30	1
2	Allowable Interest from Related Party PLH	47,886	32	2
3	Allowable Party Depreciation PLA	982	30	3
4	Allowable Related Party Utilities	10,214	5	4
5	Allowable Related Party Maintenance	32,728	6	5
6	Allowable Related Party Administrative	23,438	17	6
7	Allowable Related Party Insurance	10,721	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
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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>	166,291		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Home

# 0035527

Report Period Beginning:

7-1-15

Ending:

6-30-16

**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	10,214	0	0	0	0	0	0	0	0	0	0	10,214	5
6	Maintenance	32,728	0	0	0	0	0	0	0	0	0	0	32,728	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>42,942</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>42,942</b>	<b>8</b>
	<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>	<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>16</b>
	<b>C. General Administration</b>													
17	Administrative	23,438	0	0	0	0	0	0	0	0	0	0	23,438	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	(9)	0	0	0	0	0	0	0	0	0	0	(9)	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	10,721	0	0	0	0	0	0	0	0	0	0	10,721	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>34,150</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>34,150</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>77,092</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>77,092</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Home

# 0035527

Report Period Beginning:

7-1-15

Ending:

6-30-16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	41,304	0	0	0	0	0	0	0	0	0	0	41,304	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	47,886	0	0	0	0	0	0	0	0	0	0	47,886	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>89,190</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>89,190</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>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>166,282</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>166,282</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
				Park Lawn Assoc.	Oak Lawn	Support Organization
				Park Lawn Home, Inc.	Alsip	

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	Park Lawn Assocaiton, 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	<b>Total</b>		\$			\$	\$ *	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:

7-1-15

Ending:

6-30-16

**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 DiNolof	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								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: 7-1-15 Ending: 6-30-16

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Park Lawn Home

# 0035527

Report Period Beginning:

7-1-15

Ending: 6-30-16

**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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	See Page 27				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Park Lawn Home

# 0035527

Report Period Beginning:

7-1-15

Ending:

6-30-16

**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		7	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	Not Applicable						\$	\$				\$						
2																		
3																		
4																		
5																		
	<b>Working Capital</b>																	
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$				\$						
	<b>B. Non-Facility Related*</b>																	
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$	\$				\$						

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.)



**2015 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 2015 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 2015.

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

**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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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:

7-1-15

Ending:

6-30-16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facilities, 77,381, 1988, \$ 77,042, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 77,381, (blank), \$ 77,042, 3.



**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	15		1991	\$ 676,975	\$ 27,079	25	\$ 27,079	\$	\$ 664,074	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Garage		1995	18,306	732	25	732		15,437	9
10	Door East Side		2001	950	63	15	63		949	10
11	Bathroom Floor Tile		2001	625	16	15	16		625	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		924	14
15	Sidewalks, Handrail, & Door		2007	7,815	391	20	391		3,550	15
16	8 Toilets		2009	3,573	179	20	179		1,267	16
17	Galv Frames Shower		2009	1,833	91	20	91		640	17
18	Door Hardware		2009	3,370	168	20	168		1,190	18
19	Door Hardware Installation		2009	1,140	57	20	57		401	19
20	Wall Corner Guards		2009	1,050	70	15	70		484	20
21	Washroom Wall & Floor Tile		2009	6,880	459	15	459		3,135	21
22	Additional Door Hardware		2009	732	37	20	37		251	22
23	4 Vapor Proof lights Bath Area		2010	1,075	108	10	108		691	23
24	Fence Repair		2010	1,260	126	10	126		746	24
25	Roof		2011	16,805	1,120	15	1,120		5,228	25
26	HVAC 4 Units		2012	34,035	2,269	15	2,269		8,131	26
27	Paint in copier room		2014	975	49	20	49		102	27
28	Drywall in Copier Room		2014	650	33	20	33		68	28
29	Framing for Copier Room		2014	450	23	20	23		47	29
30	Door to Copier Room		2014	700	35	20	35		73	30
31	Permits & License		2014	365	18	20	18		38	31
32	Painting Kitchen & Dining Area		2014	2,150	108	20	108		215	32
33	Flooring in Kitchen & Dining Area		2014	4,275	214	20	214		428	33
34	Electrical in Kitchen & Dining Area		2014	2,157	108	20	108		216	34
35	Plumbing in Kitchen		2014	1,565	78	20	78		157	35
36	Counter Tops in Kitchen		2014	2,250	113	20	113		225	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:

7-1-15

Ending:

6-30-16

**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	Cabinets in Kitchen	2014	\$ 3,890	\$ 195	20	\$ 195	\$	\$ 389	37
38	Hutch Unit in Dining Area	2014	3,250	163	20	163		325	38
39	Preparation & Demolition in Kitchen & Dining Areas	2014	6,495	325	20	325		650	39
40	Repave and Strip Parking Lot	2014	33,342	1,111	20	1,111		2,222	40
41	Vinyl Flooring - Men's Side	2016	16,558	138	10	138		138	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 876,898	\$ 35,771		\$ 35,771	\$	\$ 732,453	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:

7-1-15

Ending:

6-30-16

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	\$ 4,360	\$ 4,360	\$	various	\$ 18,059	71
72	Current Year Purchases	8,729	191	191		5	191	72
73	Fully Depreciated Assets	22,224					22,224	73
74								74
75	TOTALS	\$ 66,593	\$ 4,551	\$ 4,551	\$		\$ 40,474	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See notes page 24. A small % of a few vehicles			\$ 25,648	\$ 2,568	\$ 2,568	\$	5	\$ 16,064	76
77										77
78										78
79										79
80	TOTALS			\$ 25,648	\$ 2,568	\$ 2,568	\$		\$ 16,064	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)	\$ 1,046,181	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,890	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)	\$ 788,991	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: 7-1-15

Ending: 6-30-16

**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 7-1-15

Ending 6-30-16

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

Fiscal Year Ending                      Annual Rent

12.	<u>6/30/2017</u>	\$ _____
13.	<u>6/30/2018</u>	\$ _____
14.	<u>6/30/2019</u>	\$ _____

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: \$ 6,730

Description: PACE \$2273 Copier \$4457

(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	<u>See attached listing page 25.</u>		\$ <u>33.84</u>	\$ <u>406</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>33.84</u>	\$ <u>406</u>	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>90 OJT</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	4

- (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	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	4					
					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 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	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **6-30-16**

(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	\$ 395,243	\$	1
2	Cash-Patient Deposits	93,392		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	63,724		6
7	Other Prepaid Expenses	17,819		7
8	Accounts Receivable (owners or related parties)	610,054		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,180,232	\$	10
	<b>B. Long-Term Assets</b>			
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			16
17	Accumulated Depreciation (book methods)	737,224		17
18	Deferred Charges	(510,898)		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>	\$ 226,326	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,406,558	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 116,886	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	91,227		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	455,267		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,303		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Client Reserves</u>	5,569		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 677,252	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	613,063		39
40	Mortgage Payable			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>	\$ 613,063	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,290,315	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 116,243	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,406,558	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

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

\* 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	\$ 679,157	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 679,157	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	8,619	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>	\$ 8,619	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	29,112	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 29,112	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 716,888	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	134,690	31
32	Health Care	263,109	32
33	General Administration	208,984	33
<b>B. Capital Expense</b>			
34	Ownership	72,968	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	36,224	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 715,975	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	913	41
42	<b>Income Taxes</b>	913	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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 28 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:

7-1-15

Ending:

6-30-16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	717	21,846	24.17	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	1,951	24,095	11.58	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	610	11,315	15.56	17
18	Housekeepers	1,328	14,501	9.60	18
19	Laundry				19
20	Administrator	175	13,749	69.44	20
21	Assistant Administrator				21
22	Other Administrative	759	26,521	22.98	22
23	Office Manager	1,740	41,755	20.07	23
24	Clerical	209	3,078	13.62	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)	12,602	166,508	10.52	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)	2,871	40,667	10.54	33
34	TOTAL (lines 1 - 33)	22,962	\$ 364,035 *	\$ 12.74	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	52	\$ 1,820	1-3	35
36	Medical Director	24	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	34	1,870	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	24	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	134	\$ 13,290		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		
Steve Manning	Executive Director		\$ 11,298	Workers' Compensation Insurance	\$ 9,919	IDPH License Fee	\$		
James R. Weise	Executive Director		2,451	Unemployment Compensation Insurance	1,489	Advertising: Employee Recruitment	38		
				FICA Taxes	26,679	Health Care Worker Background Check (Indicate # of checks performed <u>9</u> )	194		
				Employee Health Insurance	62,123	Patient Background Checks <u>1</u>			
				Employee Meals		License Fees	134		
				Illinois Municipal Retirement Fund (IMRF)*		Membership Fees	2,648		
				Employer Match	623	Subscriptions	659		
				Man Ben \$ 9 not included in total					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 13,749						
B. Administrative - Other									
Description			Amount						
			\$			Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 100,833	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,673		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Franczek Radelet	Legal		\$ 69			\$	Out-of-State Travel	\$	
Paycor	Computer Payroll		3,335						
Comcast	Data Processing		959				In-State Travel		
Community Service Partners	Data Processing		4,848						
James Himmel	Legal		5				Seminar Expense		
Cocalas, Westberg & Mommsen	Audit		1,385				The Arc of Illinois	276	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 10,601	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 276	

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Park Lawn Home# 0035527

Report Period Beginning:

7-1-15Ending: 6-30-16**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. \$ 1,261 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. \$ 36,224  
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 28  
Attach invoices and a summary of services for all architect and appraisal fees

Related Party Adjustment

Park Lawn Home

Lease Adjustment  
Management Benefits  
P/R & In Kind

ADJUSTMENT EXPLANATION  
2015/2016 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL	CHOICE
Total Lease	720052	87412	151822	17347	3436	205885	66653	149674	37823
LESS: Community Lease	143885	26010	75260	9686	599	8227	6730	16450	923
Related Organization	576167	61402	76562	7661	2837	197658	59923	133224	36900
Interest & Depreciation Related Organization	547623	21432	83421	7147	2487	112106	88689	226828	5513
Adjustment	28544	39970	-6859	514	350	85552	-28766	-93604	31387
Adjust Related Organization	547623	21432	83421	7147	2487	112106	88689	226828	5513
Community Lease	143885	26010	75260	9686	599	8227	6730	16450	923
Grand Total Allowable Lease	691508	47442	158681	16833	3086	120333	95419	243278	6436
Other Adjustments									
Management Benefits	-117	-16	-29	-5	-4	-24	-9	-30	0
Public Relations	-460	0	-132	0	0	0	0	0	-328
In Kind	0	0	0	0	0	0	0	0	0
	PLA	PLH							
Total Interest	129061	47851							
Total Depreciation	349609	40322							
	<u>478670</u>	<u>88173</u>							
PLH	88173								
	<u>566843</u>								
Fundraising	-19220								
	<u>547623</u>								
				PLA Depreciation				Mortgage Interest	128002
				Bldg. Depreciation		270676		Vehicle Interest	<u>1059</u>
				Equipment Depreciation		<u>78933</u>			<u>129061</u>
						<u>349609</u>			

D. Vehicle Depreciation

1 Use	2 Make, Model & Year	3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Program % Depr.	6 Straight Line Depr.	Program % Straight Line Dep.	7 Adjustment	8 Life in Years	9 Accumulated Depreciation
Activities	05 Ford Taurus	**	2007	10,922.00	0.00	6.48	\$0.00	\$0.00	\$0.00	5	\$10,922.00
Activities	05 Ford Free	**	2006	17,632.33	0.00	6.48	\$0.00	\$0.00	\$0.00	5	\$17,632.33
Activities	11 Ford E350	**	2011	34,833.00	3,484.35	6.48	\$225.79	\$3,484.35	\$225.79	5	\$34,833.00
Activities	2016 Dodge Caravan	**	2016	19,919.00	3,984.00	6.48	\$258.16	\$3,984.00	\$258.16	5	\$3,984.00
Activities	2016 Dodge Caravan	**	2016	19,919.00	3,984.00	6.48	\$258.16	\$3,984.00	\$258.16	5	\$3,984.00
Activities	2002 Toyota Sienna	**	2015	3,500.00	700.00	6.48	\$45.36	\$700.00	\$45.36	5	\$700.00
Activities	2004 Ford Freestar	**	2015	5,571.00	1,114.00	6.48	\$72.19	\$1,114.00	\$72.19	5	\$1,114.00
Activities	2004 Toyota Sienna	**	2014	5,900.00	1,180.00	6.48	\$76.46	\$1,180.00	\$76.46	5	\$2,753.00
Activities	1999 Dodge Caravan	**	2013	3,520.00	704.00	6.48	\$45.62	\$704.00	\$45.62	5	\$1,994.00
Activities	03 Ford Eldorado	*	2003	54,404.53	0.00	3.00	\$0.00	\$0.00	\$0.00	5	\$54,404.53
Activities	08 Chervrolet Braun	*	2007	32,564.00	0.00	3.00	\$0.00	\$0.00	\$0.00	5	\$32,564.00
Activities	08 Eldorado Aerotech	*	2008	52,873.00	0.00	3.00	\$0.00	\$0.00	\$0.00	5	\$52,873.00
Activities	09 Ford Eldorado Aerotech	*	2010	57,819.00	0.00	3.00	\$0.00	\$0.00	\$0.00	5	\$57,819.00
Activities	11 Ford E450 SuperDuty	*	2010	57,746.00	5,774.60	3.00	\$173.24	\$5,574.60	\$173.24	5	\$57,746.00
Activities	12 Ford ElDorado 220	*	2012	58,337.00	11,667.40	3.00	\$350.02	\$11,667.40	\$350.02	5	\$51,531.02
Activities	2013 Dodge Grand Caravan	*	2013	36,672.00	7,334.40	3.00	\$220.03	\$7,334.40	\$220.03	5	\$19,864.00
Activities	2005 Ford ElDorado Me Duty	*	2014	14,850.00	2,970.00	3.00	\$89.10	\$2,970.00	\$89.10	5	\$5,692.50
Activities	2014 Ford Starcraft	*	2014	54,435.00	10,887.00	3.00	\$326.61	\$10,887.00	\$326.61	5	\$20,413.13
	2016 Ford Starcraft	*	2015	56,806.00	11,361.20	3.00	\$340.84	\$11,361.20	\$340.84	5	\$11,361.20
	2016 Ford Starcraft	*	2016	57,755.00	2,887.75	3.00	\$86.63	\$2,887.75	\$86.63	5	\$2,887.75
	2016 Ford Starcraft	*	2016	57,755.00	0.00	3.00	\$0.00	\$0.00	\$0.00	5	\$0.00
				\$713,732.86	\$68,032.70		\$2,568.21	\$67,832.70	\$2,568.21		\$445,072.46

\* Owned by Park Lawn School Depreciation \$1,586.47

\*\* Owned by Park Lawn Association Depreciation \$981.74  
2568.21

	Program Percentag e	Cost	Total Program Cost	Program Percentage	Accumulated Depreciation	Total Program Accum Depreciation
* Owned by Park Lawn School Depreciation	0.03	\$592,016.53	\$17,760.50	0.03	\$367,156.13	\$11,014.68
** Owned by Park Lawn Association Depreciation	0.0648	\$121,716.33	\$7,887.22	0.0648	\$77,916.33	\$5,048.98
		\$713,732.86	\$25,647.71		\$445,072.46	\$16,063.66

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.

XII. C. Vehicle Rental

	1	2	3	Program	Program % of	4
	Use	Make, Model & Year	Monthly Lease Pymt.	% of Use	Monthly Lease	Rental Expense for this Period
17 Activities		05 Ford Free	\$147.00	0.0435	\$6.39	\$76.73
Activities		98 Econo Van	\$50.00	0.0435	\$2.18	\$26.10
Activities		11 Ford E350	\$581.00	0.0435	\$25.27	\$303.28
<hr/>						
21 Totals			\$778.00		\$33.84	\$406.12

## Explanation Notes:

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

## Line 7 column 2

Cable	\$2,152
Pest Control	\$11
Plant Security	\$24
	<u>\$2,187</u>

## Line 15 Column 1

Staff Trainer	\$3,500
Facility Services Coor	\$26,679
Hab Aides	\$166,508
Drivers	\$10,488
	<u>\$207,175</u>

## Schedule V. Page 3 &amp; 4

Line 5 Column 7	Allowable Related Party Costs for Utilities	\$10,214
Line 6 Column 7	Allowable Related Party Costs for Maintenance	\$32,728
Line 17 Column 7	Allowable Related Party Costs for Administrative	\$23,438
Line 26 Column 7	Allowable Related Party Costs for Insurance	\$10,721
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	\$40,322
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLA	\$982
Line 32 Column 7	Allowable Related Party Costs for Interest PLH	\$47,886
		<u>\$166,291</u>

Total Related Party Costs

## Line 34 Column 4 Includes:

Office for Park Lawn School Program	\$8,026
Portion of Rent not in HUD Payments Park Lawn School costs	\$49,835
Equipment from Park Lawn Association	\$1,656
	<u>\$59,517</u>

## Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	\$406
Equipment Rental	\$4,457
Pace Vehicle Rental	\$2,273
	<u>\$7,136</u>



Schedule VII. Part B Page 6

Park Lawn Association, Inc.

Depreciation of Vehicles \$982

Total Park Lawn Association Costs

Park Lawn Homes, Inc.

Utilities \$10,214

Maintenance \$32,728

Administration \$23,438

Taxes/Insurance \$10,721

Interest \$47,886

Depreciation Bldg. & Equipment \$40,322 \*

Total Park Lawn Homes Costs \$165,309

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

Total Related Party Adjustment on Page 5A Line 49 \$166,291

Schedule VIII. Part B

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

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

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

Administrative salaries are distributed as follows:

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

Schedule XI. Part D. Page 13

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

The vehicles with the 3.00% usage are wheel chair accessible and must be used to transport wheelchair bound clients.

Schedule XII. Part C Page 14

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn is unable to assign any vehicle to any one location, costs are assigned on a percentage of use basis. The vehicles with the 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
Franczek Radelet	3/1/2016	Telephone Consultation re: Personnel	288.00
Franczek Radelet	3/1/2016	VESSA Complaint	616.00
			<u>904.00</u>

Park Lawn Home's percentage 7.682% of total 69.45

Law office of James I	5/31/2015	Preparation & Filing of annual report & Filing fees	65
		Total for whole agency	65

Park Lawn Home's percentage 7.682% of total 4.99

Grand Total Legal 74.44