FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 0027078

Facility Name: Park Lawn Center

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Keith Wrobel **Telephone Number:** (708) 425-3344 Ext. 246
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 7-1-17 to 6-30-18 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) (Date) 10-31-18
(Type or Print Name) Steve Manning
(Title) Executive Directoe

Paid Preparer

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	41	Intermediate/DD	41	14,965	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	14,965	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	13,029			13,029	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,029			13,029	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.06%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/22/82

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] 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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

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

Tax Year: 6-30-18 Fiscal Year: 6-30-18

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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	166,934	9,027	4,724	180,685		180,685		180,685			1
2	Food Purchase		136,742		136,742		136,742		136,742			2
3	Housekeeping	43,111	8,319		51,430		51,430		51,430			3
4	Laundry	31,776	6,164		37,940		37,940		37,940			4
5	Heat and Other Utilities			78,083	78,083		78,083		78,083			5
6	Maintenance	25,569	29,537	39,845	94,951		94,951		94,951			6
7	Other (specify):* See page 27		3,345		3,345		3,345		3,345			7
8	**TOTAL General Services**	267,390	193,134	122,652	583,176		583,176		583,176			8
	B. Health Care and Programs											
9	Medical Director			4,900	4,900		4,900		4,900			9
10	Nursing and Medical Records	307,534	76,407	18,778	402,719		402,719		402,719			10
10a	Therapy			8,718	8,718		8,718		8,718			10a
11	Activities	22,890	1,098		23,988		23,988		23,988			11
12	Social Services	4,301			4,301		4,301		4,301			12
13	CNA Training											13
14	Program Transportation		10,624	11,333	21,957		21,957		21,957			14
15	Other (specify):* See page 27	854,680		25,809	880,489		880,489		880,489			15
16	**TOTAL Health Care and Programs**	1,189,405	88,129	69,538	1,347,072		1,347,072		1,347,072			16
	C. General Administration											
17	Administrative	29,104			29,104		29,104		29,104			17
18	Directors Fees											18
19	Professional Services			30,749	30,749		30,749		30,749			19
20	Dues, Fees, Subscriptions & Promotions			5,888	5,888		5,888		5,888			20
21	Clerical & General Office Expenses	123,022	30,082		153,104		153,104		153,104			21
22	Employee Benefits & Payroll Taxes			353,581	353,581		353,581		353,581			22
23	Inservice Training & Education			8,240	8,240		8,240		8,240			23
24	Travel and Seminar			358	358		358		358			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,079	18,079		18,079		18,079			26
27	Other (specify):* See page 28	43,035			43,035		43,035		43,035			27
28	**TOTAL General Administration**	195,161	30,082	416,895	642,138		642,138		642,138			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,651,956	311,345	609,085	2,572,386		2,572,386		2,572,386			29

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

Facility Name & ID Number Park Lawn Center #0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			5,540	5,540		5,540	152,485	158,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,135	15,135		15,135	69,274	84,409			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			133,782	133,782		133,782	(133,782)				34
35	Rent-Equipment & Vehicles			9,759	9,759		9,759		9,759			35
36	Other (specify):*											36
37	**TOTAL Ownership**			164,216	164,216		164,216	87,977	252,193			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			136,088	136,088		136,088		136,088			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			136,088	136,088		136,088		136,088			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,651,956	311,345	909,389	2,872,690		2,872,690	87,977	2,960,667			45

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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				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)**	$		$	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	87,977	5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 87,977		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 87,977		37

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

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

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

Park Lawn Center

ID# 0027078

Report Period Beginning: 7-1-17

Ending: 6-30-18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Depreciation from Related Party	$ 152,485	30	1
2	Allowable Interest from Related Party	69,274	32	2
3	Rent Facility & Grounds	(133,782)	34	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	87,977		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center # 0027078 **Report Period Beginning:** 7-1-17 **Ending:** 6-30-18

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	152,485	0	0	0	0	0	0	0	0	0	0	152,485	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	69,274	0	0	0	0	0	0	0	0	0	0	69,274	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(133,782)	0	0	0	0	0	0	0	0	0	0	(133,782)	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**	87,977	0	0	0	0	0	0	0	0	0	0	87,977	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)**	87,977	0	0	0	0	0	0	0	0	0	0	87,977	45

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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 Assn.	Oak Lawn	Support Organizatio

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

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

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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	James Himmel	BOD						1
2	Bonnie Price	BOD						2
3	Maureen Reilly	BOD						3
4	Jonathan Perry	BOD						4
5	Marilyn Wnuk	BOD						5
6	Chuck Jenrich	BOD						6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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	CIBC		X	Mortgage	interest	12-15-12	$ 3,000,000	$ 2,251,423	12-31-18	3.4250	$ 69,274	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,000,000	$ 2,251,423			$ 69,274	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,000,000	$ 2,251,423			$ 69,274	15

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

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

Not Applicable

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027078

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Not Applicable		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	41			1982	$ 210,000	$ 1,364	35	$ 1,364	$	$ 210,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing, Heat & AC			1982	165,500		35			165,500	9
10	Electric & Fixtures			1982	81,400		35			81,400	10
11	Elevator			1982	33,385		35			33,385	11
12	Concrete			1982	43,171		35			27,359	12
13	Sprinklers			1982	22,085		35			22,071	13
14	Bath. Access.			1982	2,450		35			2,450	14
15	Construction Int			1982	18,357		35			18,357	15
16	Carpentry			1982	23,800		35			23,800	16
17	Windows			1982	33,088		35			33,078	17
18	Ceramic Tile			1982	10,621		35			10,605	18
19	Painting			1982	10,166		35			10,151	19
20	Various Construction Materials			1982	75,966		35			75,950	20
21	Permits			1982	1,803		35			1,803	21
22	Architect Fee			1982	29,577		35			29,540	22
23	Construction Manager			1982	40,000		35			40,000	23
24	Demolition			1982	6,858		35			6,858	24
25	Windows			1983	4,258		25			4,258	25
26	Sewer & Sump Pump			1983	4,933		10			4,933	26
27	Windows			1986	850		25			850	27
28	Generator			1986	15,785		20			15,785	28
29	Fence/Gate			1993	2,053		10			2,053	29
30	Roof Repair			1997	26,382		15			26,382	30
31	Tile Main area and Floor Patch			2001	5,857		10			5,857	31
32	Compressor			2004	2,475	165	15	165		2,310	32
33	4 Stage Chiller			2005	1,285	85	15	85		1,184	33
34	Elevator Pump			2005	6,200		10			6,200	34
35	General Contractor Job Superintendent			2007	180,564	4,514	40	4,514		50,783	35
36	General Contractor Fees			2007	210,949	5,274	40	5,274		59,332	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ins & Permits	2007	$ 184,211	$ 4,605	40	$ 4,605	$	$ 51,807	37
38	Estimate Contingency	2007	1,471	37	40	37		416	38
39	Roofing	2007	185,247	4,631	40	4,631		52,099	39
40	Metal Wall Panels	2007	17,760	444	40	444		4,995	40
41	Sun Screens	2007	46,408	1,160	40	1,160		13,050	41
42	HVAC	2007	230,756	5,769	40	5,769		64,901	42
43	Electrial	2007	366,412	9,160	40	9,160		103,050	43
44	Final Cleaning	2007	1,145	29	40	29		326	44
45	Selective Demolition	2007	39,425	986	40	986		11,092	45
46	Earthwork	2007	103,726	2,593	40	2,593		29,171	46
47	Asphalt Paving	2007	56,525	1,413	40	1,413		15,903	47
48	Fencing	2007	12,113	303	40	303		3,409	48
49	Landscapomg	2007	23,679	592	40	592		6,660	49
50	Concrete	2007	148,644	3,716	40	3,716		41,805	50
51	Steel	2007	18,829	471	40	471		5,298	51
52	Carpentry	2007	592,248	14,806	40	14,806		167,627	52
53	Millwork	2007	35,126	878	40	878		9,878	53
54	Drywall & acoustical	2007	233,229	5,831	40	5,831		65,598	54
55	Calking	2007	4,232	106	40	106		1,192	55
56	Door & Hardware	2007	77,373	1,934	40	1,934		21,758	56
57	R/R Coiling Doors	2007	3,148	79	40	79		888	57
58	Overhead Doors	2007	3,450	86	40	86		968	58
59	Aluminum Entrances	2007	67,203	1,680	40	1,680		18,900	59
60	Wood Windows	2007	82,549	2,064	40	2,064		23,220	60
61	Tile & Carpet	2007	126,869	3,172	40	3,172		35,685	61
62	Painting	2007	47,690	1,192	40	1,192		13,410	62
63	Toilet Acc/Floor Mat/ Fire Ext/ Tack board	2007	15,955	399	40	399		4,389	63
64	Aceovyn Wall Protection	2007	20,486	512	40	512		5,760	64
65	Fire Protection	2007	112,086	2,802	40	2,802		31,523	65
66	Plumbing	2007	387,850	9,696	40	9,696		109,080	66
67	Low Voltage	2007	20,482	512	40	512		5,760	67
68	Fire Hydrant	2007	9,975	249	40	249		2,802	68
69	Two Monument Signs	2007	4,750	119	40	119		1,338	69
70	TOTAL (lines 4 thru 69)		$ 4,550,870	$ 93,428		$ 93,428	$	$ 1,895,992	70

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,550,870	$ 93,428		$ 93,428	$	$ 1,895,992	1
2	Metal Studs	2007	13,225	331	40	331		3,723	2
3	Architect	2007	348,281	8,707	40	8,707		97,954	3
4	Legal	2007	4,095	102	40	102		1,148	4
5	Soil Boring	2007	1,200	30	40	30		338	5
6	Survey	2007	2,300	58	40	58		652	6
7	Phone System	2007	12,262	307	40	307		3,453	7
8	Title Company Fees	2007	5,410	135	40	135		1,519	8
9	General Contractor Job Superintendent	2007	22,050	551	40	551		5,786	9
10	General Contractor Fees	2007	71,712	1,793	40	1,793		18,826	10
11	Roofing	2008	53,578	1,339	40	1,339		13,960	11
12	Sun Screens	2008	27,467	687	40	687		7,213	12
13	HVAC	2008	42,548	1,064	40	1,064		11,146	13
14	Electricial	2008	42,114	1,053	40	1,053		11,056	14
15	Selective Demolition	2008	2,018	50	40	50		525	15
16	Earthwork	2008	5,459	136	40	136		1,428	16
17	Asphalt Paving	2008	2,975	74	40	74		777	17
18	Fencing	2008	638	16	40	16		168	18
19	Landscaping	2008	8,958	224	40	224		2,395	19
20	Concrete	2008	7,823	196	40	196		2,058	20
21	Steel	2008	3,641	91	40	91		956	21
22	Carpntry	2008	31,944	799	40	799		8,389	22
23	Millwork	2008	11,554	289	40	289		3,034	23
24	Drywall & Acoustical	2008	54,781	1,370	40	1,370		14,385	24
25	Doors & Hardware	2008	5,007	125	40	125		1,312	25
26	Aluminum Entrances	2008	8,517	213	40	213		2,236	26
27	Wood Windows	2008	1,395	35	40	35		367	27
28	Tile & Carpet	2008	12,794	320	40	320		3,360	28
29	Painting	2008	23,111	578	40	578		6,243	29
30	Toilet Acc/Floor/Mat/Fire Ext/ Tack Board	2008	2,465	62	40	62		657	30
31	Acrovyn Wall Protection	2008	472	12	40	12		126	31
32	Fire Protection	2008	37,852	946	40	946		9,933	32
33	Plumbing	2008	41,841	1,043	40	1,043		11,014	33
34	TOTAL (lines 1 thru 33)		$ 5,460,357	$ 116,164		$ 116,164	$	$ 2,142,129	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,460,357	$ 116,164		$ 116,164	$	$ 2,142,129	1
2	Low Voltage	2008	23,516	588	40	588		5,292	2
3	Fire Hydrant	2008	525	13	40	13		117	3
4	Two Monument Signs	2008	12,250	306	40	306		2,754	4
5	Metal Studs	2008	4,295	107	40	107		963	5
6	Architect	2008	1,969	49	40	49		441	6
7	Phone System	2008	10,053	251	40	251		2,259	7
8	Aquarium	2009	7,827	783	10	783		7,047	8
9	Artwork	2009	1,510	151	10	151		1,359	9
10	Dedication Sign	2009	2,553	54	40	54		486	10
11	Two Electric Heaters	2009	1,121	28	40	28		252	11
12	Vinyl Tile Front Entrance	2009	1,468	37	40	37		333	12
13	Wallcovering & Chair Rail	2009	3,992	100	40	100		900	13
14	Masonary Restoration	2009	3,685	184	20	184		1,656	14
15	Tuckpointing Bldg.	2010	9,800	490	20	490		4,247	15
16	Parking Lot Lighting	2010	3,480	174	20	174		1,465	16
17	Pump Work	2010	1,522	101	15	101		853	17
18	Two Marley Heaters	2010	2,618	261	10	261		2,158	18
19	Door Hardware	2010	1,488	74	20	74		594	19
20	Crack filling/sealcoating of lot	2010	4,747	475	10	475		3,759	20
21	Exhaust Fan add on Elevator Room	2011	2,775	278	10	278		2,013	21
22	Canopy Sprinkler Installation	2011	9,290	619	15	619		4,386	22
23	Completion of River Rock to CR Drive	2011	1,097	110	10	110		768	23
24	Redo Center Landscapting	2011	5,869	391	15	391		2,477	24
25	Water Heater	2012	3,082	308	10	308		1,695	25
26	Sprinkler Pipe Chases	2013	4,172	209	20	209		1,096	26
27	Modifications to Fire Sprinkler Piping	2013	12,150	608	20	608		3,190	27
28	Swing Door	2014	1,920	96	20	96		352	28
29	Sealcoating, replace 4 wheel stops	2014	4,685	937	20	937		3,748	29
30	Trane RTU Economizer	2016	4,429	443	10	443		960	30
31	Activity Room Ductless AC split system	2016	8,843	884	10	884		1,842	31
32	PLC Stairwell Doors	2016	10,422	304	20	304		608	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,627,510	$ 125,577		$ 125,577	$	$ 2,202,199	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,627,510	$ 125,577		$ 125,577	$	$ 2,202,199	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,627,510	$ 125,577		$ 125,577	$	$ 2,202,199	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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	$ 384,364	$ 25,360	$ 25,360	$	various	$ 234,203	71
72	Current Year Purchases	4,995	342	342		various	342	72
73	Fully Depreciated Assets	203,503					203,503	73
74								74
75	TOTALS	$ 592,862	$ 25,702	$ 25,702	$		$ 438,048	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 Page 25	various	various	$ 35,110	$ 6,746	$ 6,746	$	5	$ 17,801	76
77										77
78										78
79										79
80	TOTALS			$ 35,110	$ 6,746	$ 6,746	$		$ 17,801	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,445,482	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,025	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,025	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)	$ 2,658,048	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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
Ending

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

	Fiscal Year Ending	Annual Rent
12.	06/30/2019	$
13.	06/30/2020	$
14.	06/30/2021	$

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: $ 9,759 Description: PACE $3729 , Copier $6030
(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 age 26		$ 106.48	$ 1,277	17
18					18
19					19
20					20
21	TOTAL		$ 106.48	$ 1,277	21

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(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.)

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

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

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6-30-18 (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	$ 434,376	$	1
2	Cash-Patient Deposits	106,695		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,030,052		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,748		6
7	Other Prepaid Expenses	5,856		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,646,727	$	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	834,426		16
17	Accumulated Depreciation (book methods)	(644,074)		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)**	$ 190,352	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,837,079	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,025	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	104,158		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	520,905		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,242		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	Reserve for Clients Activities	7,195		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 769,525	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	951,707		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)**	$ 951,707	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,721,232	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 113,707	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,837,079	$	48

*(See instructions.)

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 115,847	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 115,847	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,140)	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)**	$ (2,140)	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)**	$ 113,707	24 *

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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	$ 2,289,262	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,289,262	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	19,503	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)**	$ 19,503	23
	D. Non-Operating Revenue		
24	Contributions	560,035	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 560,035	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,868,800	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	583,176	31
32	Health Care	1,347,072	32
33	General Administration	642,138	33
	B. Capital Expense		
34	Ownership	164,216	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	136,088	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,872,690	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,890)	41
42	**Income Taxes**	2,140	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,140)	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? _____ If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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	1,025	1,173	$ 40,130	$ 34.21	1
2	Assistant Director of Nursing	1,653	2,735	64,616	23.63	2
3	Registered Nurses	3,875	5,385	124,276	23.08	3
4	Licensed Practical Nurses	2,919	3,535	78,512	22.21	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	1,633	1,915	22,890	11.95	10
11	Social Service Workers	120	152	4,301	28.30	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,495	36,867	14.78	13
14	Head Cook	2,588	3,285	38,526	11.73	14
15	Cook Helpers/Assistants	7,459	8,325	91,541	11.00	15
16	Dishwashers					16
17	Maintenance Workers	2,100	2,295	25,569	11.14	17
18	Housekeepers	9	4,089	43,111	10.54	18
19	Laundry	2,637	2,879	31,776	11.04	19
20	Administrator	445	504	29,104	57.75	20
21	Assistant Administrator					21
22	Other Administrative	2,420	2,788	67,097	24.07	22
23	Office Manager	2,934	3,182	45,553	14.32	23
24	Clerical	785	844	10,372	12.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,099	2,861	95,040	33.22	28
29	Resident Services Coordinator	165	2,981	48,215	16.17	29
30	Habilitation Aides (DD Homes)	48,628	54,982	711,425	12.94	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See page 28	3,070	3,175	43,035	13.55	33
34	TOTAL (lines 1 - 33)	88,404	109,580	$ 1,651,956 *	$ 15.08	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	105	$ 4,724	1-3	35
36	Medical Director	33	4,900	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	158	8,718	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant			10-3	45
46	Other(specify) Psychiatric	23	5,700	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	319	$ 24,042		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	196	$ 12,093	10-3	50
51	Licensed Practical Nurses	24	985	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	220	$ 13,078		53

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Steve Manning	Executive Director		$ 29,104
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 29,104

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
Cocalas, Westberg & Mommsen	Audit	$ 3,756
Community Service Partners	Audit	350
Comcast	Data Processing	1,255
Community Service Partners	Data Processing	10,894
James Himmel	Legal	14
Paycor	Computer Payroll	14,272
		208
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 30,749

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,680
Unemployment Compensation Insurance	4,957
FICA Taxes	120,965
Employee Health Insurance	188,495
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Match	4,484
TOTAL (agree to Schedule V, line 22, col.8)	$ 353,581

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12
Health Care Worker Background Check	
(Indicate # of checks performed)	981
Patient Background Checks	
Membership Fees	4,290
License Fees	438
Subscriptions	167
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,888

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
The Arc of Illinois	358
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 358

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-17 Ending: 6-30-18

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?
If YES, give association name and amount. **No**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **36,382** 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 fo
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 Departmen
during this cost report period. $ **136,088**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe
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?
Firm Name: **Cocalas, Westberg, Mommsen, Ltd.**

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

Related Party Adjustment

Park Lawn Center

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2017/2018 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL	CHOICE
Total Lease	656268	27625	135135	13675	2276	200569	65182	140941	70865
LESS: Community Leas	129673	20088	66469	7301	0	7496	2250	10777	15292
Related Organization	526595	7537	68666	6374	2276	193073	62932	130164	55573
Interest & Depreciation Related Organization	513454	23696	82638	7668	2374	102799	63304	221881	9094
Adjustment	13141	-16159	-13972	-1294	-98	90274	-372	-91717	46479
Adjust Related Organiza	513454	23696	82638	7668	2374	102799	63304	221881	9094
Community Lease	129673	20088	66469	7301	0	7496	2250	10777	15292
Grand Total Allowable L	643127	43784	149107	14969	2374	110295	65554	232658	24386
Other Adjustments									
Management Benefits	0	0	0	0	0	0	0	0	0
Public Relations	0	0	0	0	0	0	0	0	0
In Kind	0	0	0	0	0	0	0	0	0

	PLA	PLH
Total Interest	111203	45506
Total Depreciation	359717	17096
	470920	62602
PLH	62602	
	533522	
Fundraising	-20068	
	513454	

PLA Depreciation	
Bldg. Depreciation	276750
Equipment Depreciation	82967
	359717

Mortgage Interest	109683
Vehicle Interest	1520
	111203

1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Prog. % of Depreciatic	6 Straight Line Depreciation	Program % of Straight Line Depr.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation	
Medical Appt:	2016 Dodge Caravan	**	2016	$17,799.00	$3,559.85	0.0871	310.06	3,559.85	310.06		5	$5,636.43	
Medical Appt:	2016 Dodge Caravan	**	2016	$17,799.00	$3,559.85	0.0871	310.06	3,559.85	310.06		5	$5,636.43	
Medical Appt:	2016 Dodge Caravan	**	2016	$19,919.00	$3,983.80	0.0871	346.99	$3,983.80	346.99		5	$10,291.48	
Medical Appt:	2016 Dodge Caravan	**	2016	$19,919.00	$3,983.80	0.0871	346.99	$3,983.80	346.99		5	$10,291.48	
Medical Appt:	2002 Toyota Sienna	**	2015	$3,500.00	$700.00	0.0871	60.97	$700.00	60.97		5	$1,808.33	
Medical Appt:	2004 Ford Freestar	**	2015	$5,571.00	$1,114.20	0.0871	97.05	$1,114.20	97.05		5	$3,064.05	
Medical Appt:	2004 Toyota Sienna	**	2014	$5,900.00	$1,180.00	0.0871	102.78	$1,180.00	102.78		5	$5,113.33	
Medical Appt:	1999 Dodge Caravan	**	2013	$3,520.00	$1,997.67	0.0871	174.00	$1,997.67	174.00		5	$2,698.67	$44,540.21
Medical Appt:	2012 Ford ElDroado Bus	*	2012	$58,337.00	$6,805.98	8	$544.48	$6,805.98	$544.48		5	$58,337.00	
Medical Appt:	2013 Dodge Grand Caravan	*	2013	$36,672.00	$7,334.40	8	$586.75	$7,334.40	$586.75		5	36,672.00	
Medical Appt:	2005 Ford ElDorado Medium	*	2005	$14,850.00	$2,970.00	8	$237.60	$2,970.00	$237.60		5	14,602.50	
Medical Appt:	2014 Ford Starcraft	*	2014	$54,435.00	$10,887.00	8	$870.96	$10,887.00	$870.96		5	53,074.13	
Medical Appt:	2016 Ford Starcraft	*	2015	$56,806.00	$11,361.20	8	$908.90	$11,361.20	$908.90		5	45,444.80	
Medical Appt:	2016 Ford Starcraft	*	2016	$57,755.00	$11,551.00	8	$924.08	$11,551.00	$924.08		5	37,540.75	
Medical Appt:	2016 Ford Starcraft	*	2016	$57,755.00	$11,551.00	8	$924.08	$11,551.00	$924.08		5	34,653.00	$280,324.18
				$430,537.00	$82,539.76		$6,745.74	$82,539.76	$6,745.74			$324,864.39	$324,864.39

*

**

*	Owned by Park Lawn School	Depreciation	$62,460.58	$4,996.85	$4,996.85	
**	Owned by Park Lawn Assoc.	Depreciation	$20,079.18	$1,748.90	$1,748.90	
			$82,539.76	$6,745.74	$6,745.74	$0.00

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

	Program %	Cost	Program Cost	Program %	Accum. Depre	Program Accum	Deprec.
Owned by Park Lawn School	0.08	$336,610.00	$26,928.80	0.08	$280,324.18	$22,425.93	
Owned by Park Lawn Assoc.	0.0871	$93,927.00	$8,181.04	0.0871	$44,540.21	$3,879.45	
		$430,537.00	$35,109.84		$324,864.39	$26,305.39	

XII. C. Vehicle Rental

	1 Use	2 Make, Model & Year	3 Monthly Lease Pymt	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
	Activities	2016 Dodge Caravan	$332.00	0.08018	26.62	$319.44
	Activities	2016 Dodge Caravan	$332.00	0.08018	26.62	$319.44
	Activities	2016 Dodge Caravan	$332.00	0.08018	26.62	$319.44
	Activities	2016 Dodge Caravan	$332.00	0.08018	26.62	$319.44
21	Totals		$1,328.00		106.48	$1,277.75

Explanation Notes:

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

Line 7 Column 2

Cable	715
Pest Control	$1,700
Plant Security	$930
	$3,345

Line 15 Column 1

QMRP	$95,040
Res. Serv. Coor.	$48,215
Hab. Aides	$711,425
	$854,680

Schedule V. Page 4

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

Building Depreciation	127,022	
Vehicle Depreciation	1,749	
Equipment Depreciation	23,714	
		$152,485

Line 35 Column 8 Community Leased equipment: Copier $9,441, PACE $3729

Schedule VII. Part B

Park Lawn Association, Inc.		
Building Rental not allowed		($133,782)
Allowable Building Interest		$69,274
Depreciation Allowed		
Building	127,022	
Vehicle Depreciation	1,749	
Equipment	23,714	
Total Depreciation Allowed *	$152,485	$152,485

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

Total Related Party Adjustment Detailed on Page 5A line 49 $87,977.00

Schedule VIII. Part B

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

Schedule IX Interest Expense	Column 10	
CIBA	This programs mortgage interest allowed from related party	$69,274.00

Schedule XI. Part D

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

Schedule XII Part C Page 14

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

Schedule XIII. B Page 15

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

Schedule XVIII. Page 19

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

Schdeule XVIII. Page 20 Line 33	Hrs. Worked	Hrs. Paid & Accrued	
Drivers	2625	2668	$32,305
Trainer	445	507	$10,730
	3070	3175	$43,035

Schedule XX. Page 22

Question 15 No Employee meals are served