

Facility Name & ID Number Park Lawn Center

0027078 Report Period Beginning: 7/1/14 Ending: 6/30/15

III. STATISTICAL DATA

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

	1	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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	14,222			14,222
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	14,222			14,222

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.04%

D. How many bed-hold days during this year were paid by the Department? 205 (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)

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 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 If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6-30-15 Fiscal Year: 6-30-15

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

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
	A. General Services										
1	Dietary	162,119	6,147	7,410	175,676		175,676	175,676			1
2	Food Purchase		150,953		150,953		150,953	150,953			2
3	Housekeeping	27,965	7,276		35,241		35,241	35,241			3
4	Laundry	21,616	12,410		34,026		34,026	34,026			4
5	Heat and Other Utilities			74,096	74,096		74,096	74,096			5
6	Maintenance	34,384	24,515	36,328	95,227		95,227	95,227			6
7	Other (specify):*		5,962		5,962		5,962	5,962			7
8	TOTAL General Services	246,084	207,263	117,834	571,181		571,181	571,181			8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400	8,400			9
10	Nursing and Medical Records	312,410	77,017	6,735	396,162		396,162	396,162			10
10a	Therapy			8,360	8,360		8,360	8,360			10a
11	Activities	3,407	1,134		4,541		4,541	4,541			11
12	Social Services										12
13	CNA Training										13
14	Program Transportation	26,280	6,549	3,750	36,579		36,579	36,579			14
15	Other (specify):* Notes page 27	828,156			828,156		828,156	828,156			15
16	TOTAL Health Care and Programs	1,170,253	84,700	27,245	1,282,198		1,282,198	1,282,198			16
	C. General Administration										
17	Administrative	32,765			32,765		32,765	32,765			17
18	Directors Fees										18
19	Professional Services			35,212	35,212		35,212	35,212			19
20	Dues, Fees, Subscriptions & Promotions			6,812	6,812		6,812	6,812			20
21	Clerical & General Office Expenses	127,732	29,833		157,565		157,565	157,565			21
22	Employee Benefits & Payroll Taxes			369,071	369,071		369,071	(1,661)	367,410		22
23	Inservice Training & Education			4,330	4,330		4,330		4,330		23
24	Travel and Seminar			291	291		291		291		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			16,209	16,209		16,209		16,209		26
27	Other (specify):*										27
28	TOTAL General Administration	160,497	29,833	431,925	622,255		622,255	(1,661)	620,594		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,576,834	321,796	577,004	2,475,634		2,475,634	(1,661)	2,473,973		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,979	3,979	(54)	3,925	174,676	178,601			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,354	6,354		6,354	76,204	82,558			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			131,048	131,048		131,048	(131,048)				34
35	Rent-Equipment & Vehicles			18,945	18,945		18,945	(5,068)	13,877			35
36	Other (specify):* Unallowed Depreciation					54	54		54			36
37	TOTAL Ownership			160,326	160,326		160,326	114,764	275,090			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			141,784	141,784		141,784		141,784			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			141,784	141,784		141,784		141,784			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,576,834	321,796	879,114	2,777,744		2,777,744	113,103	2,890,847			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: 7/1/14

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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	(1,661)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,661)		\$	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	114,764	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 114,764		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 113,103		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	TOTAL (C): (sum of lines 38-46)			\$		47

Park Lawn Center

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Allowable Depreciation fraom Related Party	\$ 174,676	30	1
2	Allowable Interest from Related Party	76,204	32	2
3	Rent-Facility & Grounds	(131,048)	34	3
4	Rent Equipment & Vehicles	(5,068)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	114,764		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7/1/14

Ending:

6/30/15

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	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	(1,661)	0	0	0	0	0	0	0	0	0	0	(1,661)	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	(1,661)	0	0	0	0	0	0	0	0	0	0	(1,661)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,661)	0	0	0	0	0	0	0	0	0	0	(1,661)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center

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Report Period Beginning:

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6/30/15

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	174,676	0	0	0	0	0	0	0	0	0	0	174,676	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	76,204	0	0	0	0	0	0	0	0	0	0	76,204	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(131,048)	0	0	0	0	0	0	0	0	0	0	(131,048)	34
35	Rent-Equipment & Vehicles	(5,068)	0	0	0	0	0	0	0	0	0	0	(5,068)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	114,764	0	114,764	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	113,103	0	0	0	0	0	0	0	0	0	0	113,103	45

VII. RELATED PARTIES

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

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

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

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

1	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 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:

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6/30/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James Himmel	BOD						1
2	Bonnie Price	BOD						2
3	Maureen Reilly	BOD						3
4	Jonathan Perry	BOD						4
5	Steve Janiszewski	BOD						5
6	Marilyn Wnuk	BOD						6
7	Chuck Jenrich	BOD						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

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0027078

Report Period Beginning:

7/1/14

Ending:

6/30/15

VII. RELATED PARTIES (continued)

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

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

	1 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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Private Bank		X	Mortgsge	interst	12-15-12	\$ 3,000,000	\$	1-1-18	2.9250	\$ 76,204	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 3,000,000	\$			\$ 76,204	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	\$			\$ 76,204	15				

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																					
1. Real Estate Tax accrual used on 2014 report.		\$	1																																		
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																																		
3. Under or (over) accrual (line 2 minus line 1).		\$	3																																		
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																																		
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																																		
Real Estate Tax History:																																					
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td>_____</td><td>8</td></tr> <tr><td>2011</td><td>_____</td><td>9</td></tr> <tr><td>2012</td><td>_____</td><td>10</td></tr> <tr><td>2013</td><td>_____</td><td>11</td></tr> <tr><td>2014</td><td>_____</td><td>12</td></tr> </table>	2010	_____	8	2011	_____	9	2012	_____	10	2013	_____	11	2014	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2014	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2010	_____	8																																			
2011	_____	9																																			
2012	_____	10																																			
2013	_____	11																																			
2014	_____	12																																			
FOR BHF USE ONLY																																					
13	FROM R. E. TAX STATEMENT FOR 2014	\$	13																																		
14	PLUS APPEAL COST FROM LINE 5	\$	14																																		
15	LESS REFUND FROM LINE 6	\$	15																																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																		
Not Applicable																																					

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn 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 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Park Lawn Center

0027078 Report Period Beginning:

7/1/14 Ending:

6/30/15

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 (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).

N/A

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: Completely Amortized 6-30-08 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facilities</u>	<u>124,955</u>	<u>1981</u>	<u>\$ 190,000</u>	1
2					2
3	TOTALS	124,955		\$ 190,000	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			1982	\$ 210,000	\$ 6,000	35	\$ 6,000		\$ 196,636	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Plumbing, Heat & AC		1982	165,500	4,729	35	4,729		156,057	9
10	Electric & Fixtures		1982	81,400	2,326	35	2,326		76,758	10
11	Elevator		1982	33,385	954	35	954		31,482	11
12	Concrete		1982	43,171	1,233	35	1,233		24,893	12
13	Sprinklers		1982	22,085	631	35	631		20,809	13
14	Bath. Access.		1982	2,450	70	35	70		2,310	14
15	Construction Int		1982	18,357	525	35	525		17,325	15
16	Carpentry		1982	23,800	680	35	680		22,440	16
17	Windows		1982	33,088	945	35	945		31,188	17
18	Ceramic Tile		1982	10,621	303	35	303		9,999	18
19	Painting		1982	10,166	290	35	290		9,571	19
20	Various Construction Materials		1982	75,966	2,170	35	2,170		71,610	20
21	Permits		1982	1,803	52	35	52		1,716	21
22	Architect Fee		1982	29,577	844	35	844		27,852	22
23	Construction Manager		1982	40,000	1,143	35	1,143		37,719	23
24	Demolition		1982	6,858	196	35	196		6,468	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		1,815	32
33	4 Stage Chiller		2005	1,285	85	15	85		929	33
34	Elevator Pump		2005	6,200	620	10	620		5,373	34
35	General Contractor Job Superintendent		2007	180,564	4,514	40	4,514		37,241	35
36	General Contractor Fees		2007	210,949	5,274	40	5,274		43,510	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:

7/1/14

Ending:

6/30/15

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

1	2	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	Ins & Permits	2007	\$ 184,211	\$ 4,605	40	\$ 4,605	\$	\$ 37,992	37
38	Estimate Contingency	2007	1,471	37	40	37		305	38
39	Roofing	2007	185,247	4,631	40	4,631		38,206	39
40	Metal Wall Panels	2007	17,760	444	40	444		3,663	40
41	Sun Screens	2007	46,408	1,160	40	1,160		9,570	41
42	HVAC	2007	230,756	5,769	40	5,769		47,594	42
43	Electrial	2007	366,412	9,160	40	9,160		75,570	43
44	Final Cleaning	2007	1,145	29	40	29		239	44
45	Selective Demolition	2007	39,425	986	40	986		8,134	45
46	Earthwork	2007	103,726	2,593	40	2,593		21,392	46
47	Asphalt Paving	2007	56,525	1,413	40	1,413		11,664	47
48	Fencing	2007	12,113	303	40	303		2,500	48
49	Landscapomg	2007	23,679	592	40	592		4,884	49
50	Concrete	2007	148,644	3,716	40	3,716		30,657	50
51	Steel	2007	18,829	471	40	471		3,885	51
52	Carpentry	2007	592,248	14,806	40	14,806		123,209	52
53	Millwork	2007	35,126	878	40	878		7,244	53
54	Drywall & acoustical	2007	233,229	5,831	40	5,831		48,105	54
55	Calking	2007	4,232	106	40	106		874	55
56	Door & Hardware	2007	77,373	1,934	40	1,934		15,956	56
57	R/R Coiling Doors	2007	3,148	79	40	79		651	57
58	Overhead Doors	2007	3,450	86	40	86		710	58
59	Aluminum Entrances	2007	67,203	1,680	40	1,680		13,860	59
60	Wood Windows	2007	82,549	2,064	40	2,064		17,028	60
61	Tile & Carpet	2007	126,869	3,172	40	3,172		26,169	61
62	Painting	2007	47,690	1,192	40	1,192		9,834	62
63	Toilet Acc/Floor Mat/ Fire Ext/ Tack board	2007	15,955	399	40	399		3,192	63
64	Aceovyn Wall Protection	2007	20,486	512	40	512		4,224	64
65	Fire Protection	2007	112,086	2,802	40	2,802		23,117	65
66	Plumbing	2007	387,850	9,696	40	9,696		79,992	66
67	Low Voltage	2007	20,482	512	40	512		4,224	67
68	Fire Hydrant	2007	9,975	249	40	249		2,055	68
69	Two Monument Signs	2007	4,750	119	40	119		981	69
70	TOTAL (lines 4 thru 69)		\$ 4,550,870	\$ 115,775		\$ 115,775	\$	\$ 1,571,499	70

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

Facility Name & ID Number Park Lawn Center

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,550,870	\$ 115,775		\$ 115,775	\$	\$ 1,571,499	1
2	Metal Studs	2007	13,225	331	40	331		2,730	2
3	Architect	2007	348,281	8,707	40	8,707		71,833	3
4	Legal	2007	4,095	102	40	102		842	4
5	Soil Boring	2007	1,200	30	40	30		248	5
6	Survey	2007	2,300	58	40	58		478	6
7	Phone System	2007	12,262	307	40	307		2,532	7
8	Title Company Fees	2007	5,410	135	40	135		1,114	8
9	General Contractor Job Superintendent	2007	22,050	551	40	551		4,133	9
10	General Contractor Fees	2007	71,712	1,793	40	1,793		13,447	10
11	Roofing	2008	53,578	1,339	40	1,339		9,943	11
12	Sun Screens	2008	27,467	687	40	687		5,152	12
13	HVAC	2008	42,548	1,064	40	1,064		7,954	13
14	Electrical	2008	42,114	1,053	40	1,053		7,897	14
15	Selective Demolition	2008	2,018	50	40	50		375	15
16	Earthwork	2008	5,459	136	40	136		1,020	16
17	Asphalt Paving	2008	2,975	74	40	74		555	17
18	Fencing	2008	638	16	40	16		120	18
19	Landscaping	2008	8,958	224	40	224		1,723	19
20	Concrete	2008	7,823	196	40	196		1,470	20
21	Steel	2008	3,641	91	40	91		683	21
22	Carpntry	2008	31,944	799	40	799		5,992	22
23	Millwork	2008	11,554	289	40	289		2,167	23
24	Drywall & Acoustical	2008	54,781	1,370	40	1,370		10,275	24
25	Doors & Hardware	2008	5,007	125	40	125		937	25
26	Aluminum Entrances	2008	8,517	213	40	213		1,597	26
27	Wood Windows	2008	1,395	35	40	35		262	27
28	Tile & Carpet	2008	12,794	320	40	320		2,400	28
29	Painting	2008	23,111	578	40	578		4,509	29
30	Toilet Acc/Floor/Mat/Fire Ext/ Tack Board	2008	2,465	62	40	62		471	30
31	Acrovyn Wall Protection	2008	472	12	40	12		90	31
32	Fire Protection	2008	37,852	946	40	946		7,095	32
33	Plumbing	2008	41,841	1,043	40	1,043		7,885	33
34	TOTAL (lines 1 thru 33)		\$ 5,460,357	\$ 138,511		\$ 138,511	\$	\$ 1,749,428	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:

7/1/14

Ending:

6/30/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,460,357	\$ 138,511		\$ 138,511	\$	\$ 1,749,428	1
2	Low Voltage	2008	23,516	588	40	588		3,528	2
3	Fire Hydrant	2008	525	13	40	13		78	3
4	Two Monument Signs	2008	12,250	306	40	306		1,836	4
5	Metal Studs	2008	4,295	107	40	107		642	5
6	Architect	2008	1,969	49	40	49		294	6
7	Phone System	2008	10,053	251	40	251		1,506	7
8	Aquarium	2009	7,827	783	10	783		4,698	8
9	Artwork	2009	1,510	151	10	151		906	9
10	Dedication Sign	2009	2,553	54	40	54		324	10
11	Two Electric Heaters	2009	1,121	28	40	28		168	11
12	Vinyl Tile Front Entrance	2009	1,468	37	40	37		222	12
13	Wallcovering & Chair Rail	2009	3,992	100	40	100		600	13
14	Masonry Restoration	2009	3,685	184	20	184		1,104	14
15	Tuckpointing Bldg.	2010	9,800	490	20	490		2,777	15
16	Parking Lot Lighting	2010	3,480	174	20	174		943	16
17	Pump Work	2010	1,522	101	15	101		547	17
18	Two Marley Heaters	2010	2,618	261	10	261		1,614	18
19	Door Hardware	2010	1,488	74	20	74		370	19
20	Crack filling/sealcoating of lot	2010	4,747	475	10	475		2,335	20
21	Exhaust Fan add on Elevator Room	2011	2,775	278	10	278		1,180	21
22	Canopy Sprinkler Installation	2011	9,290	619	15	619		2,528	22
23	Completion of River Rock to CR Drive	2011	1,097	110	10	110		440	23
24	Redo Center Landscaping	2011	5,869	261	15	261		1,074	24
25	Water Heater	2012	3,082	308	10	308		1,001	25
26	Sprinkler Pipe Chases	2013	4,172	209	20	209		453	26
27	Modifications to Fire Sprinkler Piping	2013	12,150	608	20	608		1,419	27
28	Swing Door	2014	1,920	64	20	64		64	28
29	Sealcoating, replace 4 wheel stops	2014	4,685	937	20	937		937	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,603,816	\$ 146,131		\$ 146,131	\$	\$ 1,783,016	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 300,575	\$ 27,135	\$ 27,135	\$	various	\$ 176,770	71
72	Current Year Purchases	7,350	527	527			527	72
73	Fully Depreciated Assets	197,715				various	197,715	73
74								74
75	TOTALS	\$ 505,640	\$ 27,662	\$ 27,662	\$		\$ 375,012	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			\$ 50,364	\$ 4,808	\$ 4,808	\$	5	\$ 40,606	76
77										77
78										78
79										79
80	TOTALS			\$ 50,364	\$ 4,808	\$ 4,808	\$		\$ 40,606	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)	\$ 6,349,820	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 178,601	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,601	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)	\$ 2,198,634	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:

7/1/14

Ending:

6/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning 7/1/14

Ending 6/30/15

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. 06/30/2016 \$ 125,592

13. 06/30/2017 \$ 125,592

14. 06/30/2018 \$ 125,592

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: \$ 13,877 Description: PACE \$6070 & Copier \$ 7,807

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See attached listing page 26		\$ <u>284.35</u>	\$ <u>3,412</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>284.35</u>	\$ <u>3,412</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.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/14 Ending: 6/30/15
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</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		3	4
		1	2		
		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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	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.

Facility Name & ID Number **Park Lawn Center**

0027078

Report Period Beginning: **7/1/14**

Ending:

6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/15** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 284,300	\$	1
2	Cash-Patient Deposits	95,012		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,213		6
7	Other Prepaid Expenses	24,854		7
8	Accounts Receivable (owners or related parties)	811,895		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,312,274	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	564,908		16
17	Accumulated Depreciation (book methods)	(456,879)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 108,029	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,420,303	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 220,554	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,911		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	399,146		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,844		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Client Reserves</u>	1,649		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 724,104	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	579,956		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 579,956	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,304,060	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 116,243	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,420,303	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,347,724	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,347,724	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	11,184	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)	\$ 11,184	23
D. Non-Operating Revenue			
24	Contributions	420,465	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 420,465	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)	\$ 2,779,373	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	571,181	31
32	Health Care	1,282,198	32
33	General Administration	622,255	33
B. Capital Expense			
34	Ownership	160,326	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	141,784	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,777,744	40
41	Income before Income Taxes (line 30 minus line 40)**	1,629	41
42	Income Taxes	1,629	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	43

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

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

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

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

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

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7/1/14

Ending:

6/30/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,847	2,151	\$ 60,734	\$ 28.24	1
2	Assistant Director of Nursing	1,759	2,651	58,737	22.16	2
3	Registered Nurses	4,494	4,844	132,583	27.37	3
4	Licensed Practical Nurses	2,301	3,067	60,356	19.68	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	268	363	3,407	9.39	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,908	1,992	33,600	16.87	13
14	Head Cook	1,056	1,147	16,968	14.79	14
15	Cook Helpers/Assistants	10,736	15,263	111,551	7.31	15
16	Dishwashers					16
17	Maintenance Workers	1,942	2,093	34,384	16.43	17
18	Housekeepers	2,637	3,640	27,965	7.68	18
19	Laundry	2,318	2,807	21,616	7.70	19
20	Administrator	441	583	32,765	56.20	20
21	Assistant Administrator					21
22	Other Administrative	2,512	3,010	78,441	26.06	22
23	Office Manager	1,754	2,148	40,724	18.96	23
24	Clerical	525	657	8,567	13.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,536	6,224	97,430	15.65	28
29	Resident Services Coordinator	1,808	2,000	76,360	38.18	29
30	Habilitation Aides (DD Homes)	50,937	86,419	643,820	7.45	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See notes p 28</u>	2,813	3,171	36,826	11.61	33
34	TOTAL (lines 1 - 33)	97,592	144,230	\$ 1,576,834 *	\$ 10.93	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	247	\$ 7,410	1-3	35
36	Medical Director	67	8,400	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	152	8,360	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)	490	\$ 30,170		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 464	10-3	50
51	Licensed Practical Nurses	8	271	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 735		53

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning: 7/1/14

Ending: 6/30/15

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	
James R. Weise	Executive Director		\$ 30,695	Workers' Compensation Insurance	\$ 45,853	IDPH License Fee	\$	
Steve Manning	Executive Director		2,070	Unemployment Compensation Insurance	9,007	Advertising: Employee Recruitment	533	
				FICA Taxes	117,403	Health Care Worker Background Check	390	
				Employee Health Insurance	189,461	(Indicate # of checks performed <u>13</u>)		
				Employee Meals		Patient Background Checks <u>2</u>	20	
				Illinois Municipal Retirement Fund (IMRF)*		Membership Fees	5,365	
				Employee Match	5,686	License Fees	342	
				Mgmt Benefits of \$ 1661 not included		Subscriptions	162	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 32,765					
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)	\$ 367,410	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,812	
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
Kronos	Computer Payroll		\$ 362			\$	Out-of-State Travel	\$
Paycor	Computer Payroll		14,200					
Comcast	Date Processing		1,066					
Community Service Partners	Date Processing		16,600				In-State Travel	
Wessels Sherman	Legal		97					
Himmel	Legal		17					
Cocalas, Westberg & Mommsen	Audit		2,870				Seminar Expense	
							The ARC of IL Leadership Conference	181
							Food Safety Seminar	110
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 35,212	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 291

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Park Lawn Center# 0027078Report Period Beginning: 7/1/14Ending: 6/30/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? various
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,728 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. \$ 141,784
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 0 Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A Personal use not 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, Ltd.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes see page 29
Attach invoices and a summary of services for all architect and appraisal fees.

Related Party Adjustment

Park Lawn Center

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2014/2015 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL	
Total Lease	671769	87698	149376	17540	3531	197731	65899	149994	
LESS: Community Leas	100349	21910	41952	9017	396	6591	6606	13877	
Related Organization	571420	65788	107424	8523	3135	191140	59293	136117	
Interest & Depreciation Related Organization	547975	18974	87569	7116	2663	111946	88896	230811	
Adjustment	23445	46814	19855	1407	472	79194	-29603	-94694	
Adjust Related Organiza	547975	18974	87569	7116	2663	111946	88896	230811	
Community Lease	100349	21910	41952	9017	396	6591	6606	13877	
Grand Total Allowable L	648324	40884	129521	16133	3059	118537	95502	244688	
Other Adjustments									
Management Benefits	-6367	-856	-1580	-278	-190	-1312	-490	-1661	
Public Relations	5659	188	5471	0	0	0	0	0	
In Kind	0	0	0	0	0	0	0	0	
	PLA	PLH							
Total Interest	137109	48884							
Total Depreciation	339273	39589							
	<u>476382</u>	<u>88473</u>							
PLH	88473								
	<u>564855</u>								
Fundraising	<u>-16880</u>								
						<u>265672</u>			
						<u>73601</u>			
						<u>339273</u>			
							Mortgage Interest	135831	
							Vehicle Interest	<u>1278</u>	
								<u>137109</u>	

547975

1	2	3	4	5	6	7			
Use	Make, Model & Year	Year Acquired	Current Book Cost	Depreciation %	Prog. % of Depreciation	Straight Line of Depreciation	Program % of Straight Line Depr. Adjustments		
Medical Appt:	96 Mercury Sable	**	1996	19929	0	12.67	0.00	0	0
Medical Appt:	2005 Free Ford	**	2006	17632	0	12.67	0.00	0	0
Medical Appt:	05 Ford Taurus	**	2007	10922	0	12.67	0.00	0	0 -
Medical Appt:	2011 Ford E 350	**	2011	34833.5	6966.7	12.67	882.68	6966.7	882.68089 -
Medical Appt:	01 Light Duty Ford Eldorado	*	2002	44353	0		0.00	0	0 -
Medical Appt:	02 Mini Van Chevy Venture	*	2002	33545	0		0.00	0	0
Medical Appt:	03 Ford Eldorado	*	2003	54404.53	0		0.00	0	0
Medical Appt:	2008 Chevy Braun	*	2007	32564	0	8	0.00	0	0
Medical Appt:	2008 Eldorado Aerotech	*	2008	52873	0	8	0.00	0	0
Medical Appt:	Ford Eldorado Aerotech	*	2009	57819	6263.72	8	501.10	6263.72	501.10
Medical Appt:	2011 Ford E450 Super Duty	*	2011	57746	11549.2	8	923.94	11549.2	923.94
Medical Appt:	2012 Ford EIDroadro Bus	*	2012	58337	11667.4	8	933.39	11667.4	933.39
Medical Appt:	2013 Dodge Grand Caravan	*	2013	36,672.00	7,334.40	8	586.75	5,195.00	586.75
Medical Appt:	2005 Ford EIDorado Medium	*	2005	14,850.00	2,722.50	8	217.80	2,722.50	217.80
Medical Appt:	2014 Ford Starcraft	*	2014	54,435.00	9,526.13	8	762.09	9,526.13	762.09
				580915.03	56030.045		4807.75	53890.65	4807.75
		*							
		**							
*	Owned by Park Lawn School			Depreciation	49063.35		3925.07		3925.07
**	Owned by Park Lawn Assoc.			Depreciation	6966.70		883.00		883
					56030.05		4808.07		4808.07

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. Depr.	Program Accum. Depr.
Owned by Park Lawn School	0.08	\$497,598.53	39807.88	0.08	392171.78	31373.74

Owned by Park Lawn Assoc.

0.1267 \$83,316.50 10556.20
580915.03 50364.08

0.1267 72866.78 9232.22
465038.56 40605.96

Continuation

Life in Years	8	9
	Accumulated	Depreciation
5	19929	
5	17632.33	
5	10922	
5	24383.45	72866.78
5	44353	
5	33545	
5	54404.53	
5	32564	
5	52873	
5	57819	
5	\$51,971.40	
5	\$39,863.62	
5	\$12,529.60	392171.775
5	\$2,722.50	
5	\$9,526.13	
	465039	465038.555

XII. C. Vehicle Rental

1 Use	2 Make, Model & Year	3 Monthly Lease Pymt	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
Activities	2005 Free Ford	\$278.00	0.185	51.43	\$617.16
Activities	2005 Ford Taurus	\$278.00	0.185	51.43	\$617.16
Activities	96 Mercury Sable Station Wagon	\$200.00	0.185	37.00	\$444.00
Activities	1998 Econo Van	\$200.00	0.185	37.00	\$444.00
Activities	2011 Ford E 350	\$581.00	0.185	107.485	\$1,289.82
21 Totals		\$1,537.00		284.35	\$3,412.14

Explanation Notes:

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

Line 7 Column 2

Cable	799
Pest Control	\$4,124
Plant Security	\$1,040
	<u>\$5,963</u>

Line 15 Column 1

Staff Trainer	\$10,546
QMRP	\$97,430
Res. Serv. Coord.	\$76,360
Hab. Aides	\$643,820
	<u>\$828,156</u>

Schedule V. Page 4

Line 30 Column 5 To move depreciation of \$54 on assets acquired with Capital Acquisition Grant from DMH which is unallowed so it won't be included in depreciation number that we need to tie to.

Line 36 Column 5 Unallowed Capital Acquisition Grant Depreciation identified

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

Building Depreciation	\$146,131.00
Vehicle Depreciation	\$883.00
Equipment Depreciation	\$27,662.00
	<u>\$174,676.00</u>

Line 35 Column 8 Community Leased equipment: Copier \$6,074, PACE \$6109

Schedule VII. Part B

Park Lawn Association, Inc.	
Building Rental not allowed	(\$131,048)
Equipment Rental not allowed	(\$5,068)

Allowable Building Interest \$76,204

Depreciation Allowed		
Building	\$146,131	
Vehicle Depreciation	\$883	
Equipment	<u>\$27,662</u>	
Total Depreciation Allowed *	<u>\$174,676</u>	<u>\$174,676</u>

* 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 \$114,764.00

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

Private Bank	This programs mortgage interest allowed from related party	\$76,204.00
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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.

Schedule XVIII. Page 20 Line 33	Hrs. Worked Hrs. Paid & Accrued		
Drivers	2320	2631	\$26,280
Trainer	493	540	\$10,546
	<hr/>	<hr/>	<hr/>
	2813	3171	\$36,826

Schedule XX. Page 23

Question 15 No Employee meals are served

Schedule XIX. Part C

Legal Fees Invoices

Name	Date	Service	Cost
Wessels Sherman	7/28/2014	Monthly Flat rate for Telephone Consultation	75.00
Wessels Sherman	8/28/2014	Monthly Flat rate for Telephone Consultation	75.00
Wessels Sherman	9/28/2014	Monthly Flat rate for Telephone Consultation	75.00
Wessels Sherman	10/28/2014	Monthly Flat rate for Telephone Consultation	75.00
Wessels Sherman	11/28/2014	Monthly Flat rate for Telephone Consultation	75.00
		Total for whole agency	375.00
		Park Lawn Center's percentage 26% of total	97.50
Law office of James Himmel	5/31/2015	Preparation & Filing of annual report & Filing fee	<u>65.00</u>
		Total for whole agency	65.00
		Park Lawn Center's percentage 26% of total	16.90
		Total Legal	114.40