

Facility Name & ID Number Park Lawn Center

0027078 Report Period Beginning: 7-1-16 Ending: 6-30-17

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	13,422			13,422	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,422			13,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.69%

D. How many bed reserve days during this year were paid by the Department?
107 (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

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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6-30-17 Fiscal Year: 6-30-17

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-16 Ending: 6-30-17

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	138,830	8,937	5,879	153,646		153,646	153,646			1
2	Food Purchase		119,573		119,573		119,573	119,573			2
3	Housekeeping	30,343	7,220		37,563		37,563	37,563			3
4	Laundry	19,126	6,080		25,206		25,206	25,206			4
5	Heat and Other Utilities			62,275	62,275		62,275	62,275			5
6	Maintenance	33,472	21,126	41,072	95,670		95,670	95,670			6
7	Other (specify):*		3,182		3,182		3,182	3,182			7
8	TOTAL General Services	221,771	166,118	109,226	497,115		497,115	497,115			8
	B. Health Care and Programs										
9	Medical Director			8,450	8,450		8,450	8,450			9
10	Nursing and Medical Records	298,780	74,714	35,408	408,902		408,902	408,902			10
10a	Therapy			8,003	8,003		8,003	8,003			10a
11	Activities	29,313	596		29,909		29,909	29,909			11
12	Social Services										12
13	CNA Training										13
14	Program Transportation		8,607	7,230	15,837		15,837	15,837			14
15	Other (specify):* See page 27	815,056		23,229	838,285		838,285	838,285			15
16	TOTAL Health Care and Programs	1,143,149	83,917	82,320	1,309,386		1,309,386	1,309,386			16
	C. General Administration										
17	Administrative	35,360			35,360		35,360	35,360			17
18	Directors Fees										18
19	Professional Services			39,859	39,859		39,859	39,859			19
20	Dues, Fees, Subscriptions & Promotions			6,739	6,739		6,739	6,739			20
21	Clerical & General Office Expenses	135,444	30,751		166,195		166,195	166,195			21
22	Employee Benefits & Payroll Taxes			348,330	348,330		348,330	348,330			22
23	Inservice Training & Education			9,425	9,425		9,425	9,425			23
24	Travel and Seminar			351	351		351	351			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			17,883	17,883		17,883	17,883			26
27	Other (specify):* See Page 28	41,835			41,835		41,835	41,835			27
28	TOTAL General Administration	212,639	30,751	422,587	665,977		665,977	665,977			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,577,559	280,786	614,133	2,472,478		2,472,478	2,472,478			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:

7-1-16

Ending:

6-30-17

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			4,997	4,997		4,997	181,257	186,254			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,347	10,347		10,347	70,895	81,242			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			131,358	131,358		131,358	(131,358)				34
35	Rent-Equipment & Vehicles			14,456	14,456		14,456		14,456			35
36	Other (specify):*											36
37	TOTAL Ownership			161,158	161,158		161,158	120,794	281,952			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			138,888	138,888		138,888		138,888			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			138,888	138,888		138,888		138,888			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,577,559	280,786	914,179	2,772,524		2,772,524	120,794	2,893,318			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:

7-1-16

Ending:

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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				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

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	120,794	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 120,794		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 120,794		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

BHF USE ONLY							
48		49		50		51	
							52

Park Lawn Center

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Allowable Depreciation from Related Party	\$ 181,257	30	1
2	Allowable Interest from Related Party	70,895	32	2
3	Rent Facility & Grounds	(131,358)	34	3
4			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	120,794		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-16

Ending:

6-30-17

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	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:

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Ending:

6-30-17

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	181,257	0	0	0	0	0	0	0	0	0	0	181,257	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	70,895	0	0	0	0	0	0	0	0	0	0	70,895	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(131,358)	0	0	0	0	0	0	0	0	0	0	(131,358)	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	120,794	0	120,794	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)	120,794	0	120,794	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 Assn.	Oak Lawn	Support Organization

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:

7-1-16

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6-30-17

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: 7-1-16 Ending: 6-30-17

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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Report Period Beginning:

7-1-16

Ending: 6-30-17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Report Period Beginning:

7-1-16

Ending:

6-30-17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Private Bank		X	Mortgage	interst	12-15-12	\$ 3,000,000	\$ 2,432,112	1-1-18	2.9250	\$ 70,895	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 3,000,000	\$ 2,432,112			\$ 70,895	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	\$ 2,432,112			\$ 70,895	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.)

2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

7-1-16

Ending:

6-30-17

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:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facilities, 124,955, 1981, \$ 190,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 124,955, (blank), \$ 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	41		1982	\$ 210,000	\$ 6,000	35	\$ 6,000	\$	\$ 208,636	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Plumbing, Heat & AC		1982	165,500	4,714	35	4,714		165,500	9
10	Electric & Fixtures		1982	81,400	2,316	35	2,316		81,400	10
11	Elevator		1982	33,385	949	35	949		33,385	11
12	Concrete		1982	43,171	1,233	35	1,233		27,359	12
13	Sprinklers		1982	22,085	631	35	631		22,071	13
14	Bath. Access.		1982	2,450	70	35	70		2,450	14
15	Construction Int		1982	18,357	507	35	507		18,357	15
16	Carpentry		1982	23,800	680	35	680		23,800	16
17	Windows		1982	33,088	945	35	945		33,078	17
18	Ceramic Tile		1982	10,621	303	35	303		10,605	18
19	Painting		1982	10,166	290	35	290		10,151	19
20	Various Construction Materials		1982	75,966	2,170	35	2,170		75,950	20
21	Permits		1982	1,803	35	35	35		1,803	21
22	Architect Fee		1982	29,577	844	35	844		29,540	22
23	Construction Manager		1982	40,000	1,138	35	1,138		40,000	23
24	Demolition		1982	6,858	194	35	194		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		2,145	32
33	4 Stage Chiller		2005	1,285	85	15	85		1,099	33
34	Elevator Pump		2005	6,200	207	10	207		6,200	34
35	General Contractor Job Superintendent		2007	180,564	4,514	40	4,514		46,269	35
36	General Contractor Fees		2007	210,949	5,274	40	5,274		54,058	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:

7-1-16

Ending:

6-30-17

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	\$	\$ 47,202	37
38	Estimate Contingency	2007	1,471	37	40	37		379	38
39	Roofing	2007	185,247	4,631	40	4,631		47,468	39
40	Metal Wall Panels	2007	17,760	444	40	444		4,551	40
41	Sun Screens	2007	46,408	1,160	40	1,160		11,890	41
42	HVAC	2007	230,756	5,769	40	5,769		59,132	42
43	Electrial	2007	366,412	9,160	40	9,160		93,890	43
44	Final Cleaning	2007	1,145	29	40	29		297	44
45	Selective Demolition	2007	39,425	986	40	986		10,106	45
46	Earthwork	2007	103,726	2,593	40	2,593		26,578	46
47	Asphalt Paving	2007	56,525	1,413	40	1,413		14,490	47
48	Fencing	2007	12,113	303	40	303		3,106	48
49	Landscapomg	2007	23,679	592	40	592		6,068	49
50	Concrete	2007	148,644	3,716	40	3,716		38,089	50
51	Steel	2007	18,829	471	40	471		4,827	51
52	Carpentry	2007	592,248	14,806	40	14,806		152,821	52
53	Millwork	2007	35,126	878	40	878		9,000	53
54	Drywall & acoustical	2007	233,229	5,831	40	5,831		59,767	54
55	Calking	2007	4,232	106	40	106		1,086	55
56	Door & Hardware	2007	77,373	1,934	40	1,934		19,824	56
57	R/R Coiling Doors	2007	3,148	79	40	79		809	57
58	Overhead Doors	2007	3,450	86	40	86		882	58
59	Aluminum Entrances	2007	67,203	1,680	40	1,680		17,220	59
60	Wood Windows	2007	82,549	2,064	40	2,064		21,156	60
61	Tile & Carpet	2007	126,869	3,172	40	3,172		32,513	61
62	Painting	2007	47,690	1,192	40	1,192		12,218	62
63	Toilet Acc/Floor Mat/ Fire Ext/ Tack board	2007	15,955	399	40	399		3,990	63
64	Aceovyn Wall Protection	2007	20,486	512	40	512		5,248	64
65	Fire Protection	2007	112,086	2,802	40	2,802		28,721	65
66	Plumbing	2007	387,850	9,696	40	9,696		99,384	66
67	Low Voltage	2007	20,482	512	40	512		5,248	67
68	Fire Hydrant	2007	9,975	249	40	249		2,553	68
69	Two Monument Signs	2007	4,750	119	40	119		1,219	69
70	TOTAL (lines 4 thru 69)		\$ 4,550,870	\$ 115,290		\$ 115,290	\$	\$ 1,802,564	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:

7-1-16

Ending:

6-30-17

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	\$ 115,290		\$ 115,290	\$	\$ 1,802,564	1
2	Metal Studs	2007	13,225	331	40	331		3,392	2
3	Architect	2007	348,281	8,707	40	8,707		89,247	3
4	Legal	2007	4,095	102	40	102		1,046	4
5	Soil Boring	2007	1,200	30	40	30		308	5
6	Survey	2007	2,300	58	40	58		594	6
7	Phone System	2007	12,262	307	40	307		3,146	7
8	Title Company Fees	2007	5,410	135	40	135		1,384	8
9	General Contractor Job Superintendent	2007	22,050	551	40	551		5,235	9
10	General Contractor Fees	2007	71,712	1,793	40	1,793		17,033	10
11	Roofing	2008	53,578	1,339	40	1,339		12,621	11
12	Sun Screens	2008	27,467	687	40	687		6,526	12
13	HVAC	2008	42,548	1,064	40	1,064		10,082	13
14	Electricial	2008	42,114	1,053	40	1,053		10,003	14
15	Selective Demolition	2008	2,018	50	40	50		475	15
16	Earthwork	2008	5,459	136	40	136		1,292	16
17	Asphalt Paving	2008	2,975	74	40	74		703	17
18	Fencing	2008	638	16	40	16		152	18
19	Landscaping	2008	8,958	224	40	224		2,171	19
20	Concrete	2008	7,823	196	40	196		1,862	20
21	Steel	2008	3,641	91	40	91		865	21
22	Carpntry	2008	31,944	799	40	799		7,590	22
23	Millwork	2008	11,554	289	40	289		2,745	23
24	Drywall & Acoustical	2008	54,781	1,370	40	1,370		13,015	24
25	Doors & Hardware	2008	5,007	125	40	125		1,187	25
26	Aluminum Entrances	2008	8,517	213	40	213		2,023	26
27	Wood Windows	2008	1,395	35	40	35		332	27
28	Tile & Carpet	2008	12,794	320	40	320		3,040	28
29	Painting	2008	23,111	578	40	578		5,665	29
30	Toilet Acc/Floor/Mat/Fire Ext/ Tack Board	2008	2,465	62	40	62		595	30
31	Acrovyn Wall Protection	2008	472	12	40	12		114	31
32	Fire Protection	2008	37,852	946	40	946		8,987	32
33	Plumbing	2008	41,841	1,043	40	1,043		9,971	33
34	TOTAL (lines 1 thru 33)		\$ 5,460,357	\$ 138,026		\$ 138,026	\$	\$ 2,025,965	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:

7-1-16

Ending:

6-30-17

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	\$ 138,026		\$ 138,026		\$ 2,025,965	1
2	Low Voltage	2008	23,516	588	40	588		4,704	2
3	Fire Hydrant	2008	525	13	40	13		104	3
4	Two Monument Signs	2008	12,250	306	40	306		2,448	4
5	Metal Studs	2008	4,295	107	40	107		856	5
6	Architect	2008	1,969	49	40	49		392	6
7	Phone System	2008	10,053	251	40	251		2,008	7
8	Aquarium	2009	7,827	783	10	783		6,264	8
9	Artwork	2009	1,510	151	10	151		1,208	9
10	Dedication Sign	2009	2,553	54	40	54		432	10
11	Two Electric Heaters	2009	1,121	28	40	28		224	11
12	Vinyl Tile Front Entrance	2009	1,468	37	40	37		296	12
13	Wallcovering & Chair Rail	2009	3,992	100	40	100		800	13
14	Masonry Restoration	2009	3,685	184	20	184		1,472	14
15	Tuckpointing Bldg.	2010	9,800	490	20	490		3,757	15
16	Parking Lot Lighting	2010	3,480	174	20	174		1,291	16
17	Pump Work	2010	1,522	101	15	101		752	17
18	Two Marley Heaters	2010	2,618	261	10	261		1,897	18
19	Door Hardware	2010	1,488	74	20	74		520	19
20	Crack filling/sealcoating of lot	2010	4,747	475	10	475		3,284	20
21	Exhaust Fan add on Elevator Room	2011	2,775	278	10	278		1,735	21
22	Canopy Sprinkler Installation	2011	9,290	619	15	619		3,767	22
23	Completion of River Rock to CR Drive	2011	1,097	110	10	110		658	23
24	Redo Center Landscaping	2011	5,869	391	15	391		2,086	24
25	Water Heater	2012	3,082	308	10	308		1,387	25
26	Sprinkler Pipe Chases	2013	4,172	209	20	209		887	26
27	Modifications to Fire Sprinkler Piping	2013	12,150	608	20	608		2,582	27
28	Swing Door	2014	1,920	96	20	96		256	28
29	Sealcoating, replace 4 wheel stops	2014	4,685	937	20	937		2,811	29
30	Trane RTU Economizer	2016	4,429	443	10	443		517	30
31	Activity Room Ductless AC split system	2016	8,843	884	10	884		958	31
32	PLC Stairwell Doors	2016	10,422	304	20	304		304	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,627,510	\$ 147,439		\$ 147,439		\$ 2,076,622	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	\$ 320,501	\$ 28,784	\$ 28,784	\$	various	\$ 207,121	71
72	Current Year Purchases	63,863	3,368	3,368		various	3,368	72
73	Fully Depreciated Assets	197,715					197,715	73
74								74
75	TOTALS	\$ 582,079	\$ 32,152	\$ 32,152	\$		\$ 408,204	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	\$ 33,616	\$ 6,663	\$ 6,663	\$	5	\$ 16,925	76
77										77
78										78
79										79
80	TOTALS			\$ 33,616	\$ 6,663	\$ 6,663	\$		\$ 16,925	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)	\$ 6,433,205	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 186,254	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 186,254	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)	\$ 2,501,751	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: 7-1-16

Ending: 6-30-17

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 _____

Ending _____

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

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

12.	<u>06/30/2018</u>	\$ <u>125,592</u>
13.	<u>06/30/2019</u>	\$ <u>125,592</u>
14.	<u>06/30/2020</u>	\$ <u>125,592</u>

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 12,996 Description: PACE \$3,555 Copier \$9,441

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See attached listing page 26</u>		\$ <u>121.64</u>	\$ <u>1,460</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>121.64</u>	\$ <u>1,460</u>	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6-30-17**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 776,793	\$	1
2	Cash-Patient Deposits	94,592		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	642,816		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,411		6
7	Other Prepaid Expenses	15,753		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,601,365	\$	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	737,225		16
17	Accumulated Depreciation (book methods)	(574,495)		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)	\$ 162,730	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,764,095	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 125,268	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,478		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	471,223		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,565		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 696,534	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	951,318		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)	\$ 951,318	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,647,852	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 116,243	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,764,095	\$	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	\$ 2,268,163	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,268,163	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	16,798	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)	\$ 16,798	23
D. Non-Operating Revenue			
24	Contributions	490,538	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 490,538	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)	\$ 2,775,499	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	497,115	31
32	Health Care	1,309,386	32
33	General Administration	665,977	33
B. Capital Expense			
34	Ownership	161,158	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	138,888	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,772,524	40
41	Income before Income Taxes (line 30 minus line 40)**	2,975	41
42	Income Taxes	2,975	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? _____ 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:

7-1-16

Ending:

6-30-17

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	1,520	1,644	\$ 48,013	\$ 29.20	1
2	Assistant Director of Nursing	1,983	2,874	69,576	24.21	2
3	Registered Nurses	3,929	5,278	113,728	21.55	3
4	Licensed Practical Nurses	2,898	3,244	67,463	20.80	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	2,244	2,761	29,313	10.62	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,840	2,209	32,616	14.77	13
14	Head Cook	2,127	3,063	36,202	11.82	14
15	Cook Helpers/Assistants	7,068	7,510	70,012	9.32	15
16	Dishwashers					16
17	Maintenance Workers	1,819	2,198	33,472	15.23	17
18	Housekeepers	2,912	3,286	30,343	9.23	18
19	Laundry	2,029	2,134	19,126	8.96	19
20	Administrator	541	615	35,360	57.50	20
21	Assistant Administrator					21
22	Other Administrative	2,658	3,143	77,482	24.65	22
23	Office Manager	1,870	2,080	48,654	23.39	23
24	Clerical	439	622	9,308	14.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,640	5,128	70,635	13.77	28
29	Resident Services Coordinator	1,280	1,729	63,345	36.64	29
30	Habilitation Aides (DD Homes)	48,639	67,114	681,076	10.15	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	3,188	3,604	41,835	11.61	33
34	TOTAL (lines 1 - 33)	93,624	120,236	\$ 1,577,559 *	\$ 13.12	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	168	\$ 5,879	1-3	35
36	Medical Director	56	8,450	10.3	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	146	8,003	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	269	23,229	10-3	45
46	Other(specify) <u>Psychiatric</u>	26	6,417	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	665	\$ 51,978		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	350	\$ 21,659	10-3	50
51	Licensed Practical Nurses	192	7,333	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	542	\$ 28,992		53

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

0027078

Report Period Beginning: **7-1-16**

Ending: **6-30-17**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Steve Manning	Executive Director		\$ 35,360	Workers' Compensation Insurance	\$ 44,760	IDPH License Fee	\$		
				Unemployment Compensation Insurance	6,388	Advertising: Employee Recruitment	1,023		
				FICA Taxes	117,039	Health Care Worker Background Check (Indicate # of checks performed <u>28</u>)			
				Employee Health Insurance	175,612	Public Relations	55		
				Employee Meals		Membership Fees	4,289		
				Illinois Municipal Retirement Fund (IMRF)*		License Fees	394		
				Employee Match	4,531	Subscriptions	111		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 35,360	TOTAL (agree to Schedule V, line 22, col.8)		\$ 348,330	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense		
C. Professional Services							The Arc of IL		351
Vendor/Payee	Type		Amount				Entertainment Expense		()
Paycor	Computer Payroll		\$ 17,183				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 351
Comcast	Data Processing		984						
Community Service Partners	Data Processing		16,879						
Duffren & Co	Audit		1,875						
Cocalas, Westberg & Mommsen	Audit		2,679						
Laner Muchin Ltd	Legal		259						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 39,859						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Lawn Center# 0027078

Report Period Beginning:

7-1-16Ending: 6-30-17**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. \$ 31,214 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. \$ 138,888
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
2016/2017 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMENT	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL	CHOICE
Total Lease	718371	77565	137098	14015	3106	205150	68384	145814	67239
LESS: Community Leas	134391	20883	65707	7511	402	7981	6105	14456	11346
Related Organization	583980	56682	71391	6504	2704	197169	62279	131358	55893
Interest & Depreciation Related Organization	539078	23260	84888	7582	2484	107714	76387	227698	9065
Adjustment	44902	33422	-13497	-1078	220	89455	-14108	-96340	46828
Adjust Related Organiza	539078	23260	84888	7582	2484	107714	76387	227698	9065
Community Lease	134391	20883	65707	7511	402	7981	6105	14456	11346
Grand Total Allowable Li	673469	44143	150595	15093	2886	115695	82492	242154	20411
Other Adjustments									
Management Benefits	0	0	0	0	0	0	0	0	0
Public Relations	-250	-30	-82	-11	-5	-46	-16	-55	-5
In Kind	0	0	0	0	0	0	0	0	0
	PLA	PLH							
Total Interest	118922	46727							
Total Depreciation	364706	29035							
	<u>483628</u>	<u>75762</u>							
PLH	<u>75762</u>								
	559390								
Fundraising	<u>-20312</u>								
	539078								
						277334		Mortgage Interest	117912
						87372		Vehicle Interest	<u>1010</u>
						<u>364706</u>			118922

1	2	3	4	5	6	7	8	9		
Use	Make, Model & Year	Year Acquired	Current Book Depreciation	%	Prog. % of Depreciation	Straight Line Depreciation	Program % of Straight Line Depreciation	Life in Years	Accumulated Depreciation	
Medical Appt: 2016 Dodge Caravan	**	2016	\$19,919.00	\$3,984.00	11.465	\$456.77	\$3,984.00	\$361.75	5	\$7,967.60
Medical Appt: 2016 Dodge Caravan	**	2016	\$19,919.00	\$3,984.00	11.465	\$456.77	\$3,984.00	\$361.75	5	\$7,967.60
Medical Appt: 2002 Toyota Sienna	**	2015	\$3,500.00	\$700.00	11.465	\$80.26	\$700.00	\$63.56	5	\$1,400.00
Medical Appt: 2004 Ford Freestar	**	2015	\$5,571.00	\$1,114.00	11.465	\$127.72	\$1,114.00	\$101.15	5	\$2,228.40
Medical Appt: 2004 Toyota Sienna	**	2014	\$5,900.00	\$2,753.00	11.465	\$315.63	\$2,753.00	\$107.14	5	\$3,933.33
Medical Appt: 1999 Dodge Caravan	**	2013	\$3,520.00	\$1,997.67	11.465	\$229.03	\$1,997.67	\$63.92	5	\$2,698.67
Medical Appt: 2012 Ford EIDorado 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	\$27,198.40
Medical Appt: 2005 Ford EIDorado Medium*	*	2005	\$14,850.00	\$2,970.00	8	\$237.60	\$2,970.00	\$237.60	5	\$8,662.90
Medical Appt: 2014 Ford Starcraft	*	2014	\$54,435.00	\$10,887.00	8	\$870.96	\$10,887.00	\$870.96	5	\$31,300.13
Medical Appt: 2016 Ford Starcraft	*	2015	\$56,806.00	\$11,361.20	8	\$908.90	\$11,361.20	\$908.90	5	\$22,722.40
Medical Appt: 2016 Ford Starcraft	*	2016	\$57,755.00	\$11,551.00	8	\$924.08	\$11,551.00	\$924.08	5	\$14,248.95
Medical Appt: 2016 Ford Starcraft	*	2016	\$57,755.00	\$11,551.00	8	\$924.08	\$11,551.00	\$924.08	5	\$11,551.00
			\$394,939.00	\$76,993.25		\$6,663.02	\$76,993.25	\$6,056.12		\$200,216.38
		*								
		**								
*	Owned by Park Lawn School		Depreciation	\$62,460.58		\$4,996.85		\$4,996.85		
**	Owned by Park Lawn Assoc.		Depreciation	\$14,532.67		\$1,666.17		\$1,666.00		
				\$76,993.25		\$6,663.02		\$6,662.85	\$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. Depr	Program Accum Deprec.
Owned by Park Lawn School	0.08	\$336,610.00	\$26,928.80	0.08	\$174,020.78	\$13,921.66
Owned by Park Lawn Assoc.	0.11465	\$58,329.00	\$6,687.42	0.11465	\$26,195.60	\$3,003.33
		\$394,939.00	\$33,616.22		\$200,216.38	\$16,924.99

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	1998 Econo Van	\$109.00	0.11465	12.50	\$149.96
Activities	2011 Ford E 350	\$290.00	0.11465	33.25	\$398.98
Activities	2016 Dodge Caravan	\$331.00	0.11465	37.95	\$455.39
Activities	2016 Dodge Caravan	\$331.00	0.11465	37.95	\$455.39
21 Totals		\$1,061.00		121.64	\$1,459.72

Explanation Notes:

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

Line 7 Column 2	
Cable	503
Pest Control	\$1,739
Plant Security	<u>\$940</u>
	\$3,182
Line 15 Column 1	
QMRP	\$70,635
Res. Serv. Coord.	\$63,345
Hab. Aides	<u>\$681,076</u>
	\$815,056

Schedule V. Page 4

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

Building Depreciation	147,439	
Vehicle Depreciation	1,666	
Equipment Depreciation	<u>32,152</u>	
		\$181,257

Line 35 Column 8 Community Leased equipment: Copier \$9,441, PACE \$3555

Schedule VII. Part B

Park Lawn Association, Inc.		
Building Rental not allowed		(\$131,358)
Allowable Building Interest		\$70,895
Depreciation Allowed		
Building	147,439	
Vehicle Depreciation	1,666	
Equipment	<u>32,152</u>	
Total Depreciation Allowed *	\$181,257	<u>\$181,257</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		\$120,794.00

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	\$70,895.00
--------------	--	-------------

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	2668	2989	\$30,893
Trainer	520	615	\$10,942
	3188	3604	\$41,835

Schedule XX. Page 22

Question 15 No Employee meals are served

Schedule XIX. Part C

Legal Fees Invoices

Name	Date	Service	Cost
Laner Muchin Ltd	1/20/2017	Legal through 1-20-17 Drafting Letter & Phone Conversations	<u>1054.00</u>
		Park Lawn Center's percentage 24.6% of total	259.28