

Facility Name & ID Number Park Lawn Center

0027078 Report Period Beginning: 7-1-99 Ending: 6-30-00

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	<u>41</u>	Intermediate/DD	<u>41</u>	<u>15,006</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>41</u>	TOTALS	<u>41</u>	<u>15,006</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>13,951</u>			<u>13,951</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,951</u>			<u>13,951</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.97%

D. How many bed-hold days during this year were paid by Public Aid? 547 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9-22-82

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9-22-82 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: 6-30-00 Fiscal Year: 6-30-00

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

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-99 Ending: 6-30-00

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	108,624	3,113	4,620	116,357		116,357		116,357		1
2	Food Purchase		91,860		91,860		91,860		91,860		2
3	Housekeeping	51,258	7,327		58,585		58,585		58,585		3
4	Laundry	17,449	7,864		25,313		25,313		25,313		4
5	Heat and Other Utilities			38,868	38,868		38,868		38,868		5
6	Maintenance	42,590	23,998	3,253	69,841		69,841		69,841		6
7	Other (specify):* <u>Waste,Plant Sec.</u>		19,832		19,832		19,832		19,832		7
8	TOTAL General Services	219,921	153,994	46,741	420,656		420,656		420,656		8
	B. Health Care and Programs										
9	Medical Director			4,500	4,500		4,500		4,500		9
10	Nursing and Medical Records	198,881	58,084	14,470	271,435		271,435		271,435		10
10a	Therapy		3,793	4,581	8,374		8,374		8,374		10a
11	Activities										11
12	Social Services	9,504			9,504		9,504		9,504		12
13	Nurse Aide Training										13
14	Program Transportation	54,275	7,768	2,301	64,344		64,344		64,344		14
15	Other (specify):* <u>QMRP<ResCoor,Hab</u>	702,694			702,694		702,694		702,694		15
16	TOTAL Health Care and Programs	965,354	69,645	25,852	1,060,851		1,060,851		1,060,851		16
	C. General Administration										
17	Administrative	66,973			66,973		66,973		66,973		17
18	Directors Fees										18
19	Professional Services			10,179	10,179		10,179		10,179		19
20	Dues, Fees, Subscriptions & Promotions			6,717	6,717		6,717	(18)	6,699		20
21	Clerical & General Office Expenses	83,398	27,611		111,009		111,009		111,009		21
22	Employee Benefits & Payroll Taxes			199,611	199,611		199,611	(4,046)	195,565		22
23	Inservice Training & Education			3,880	3,880		3,880		3,880		23
24	Travel and Seminar			2,242	2,242		2,242		2,242		24
25	Other Admin. Staff Transportation		8,349		8,349		8,349		8,349		25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*			936	936		936		936		27
28	TOTAL General Administration	150,371	35,960	223,565	409,896		409,896	(4,064)	405,832		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,335,646	259,599	296,158	1,891,403		1,891,403	(4,064)	1,887,339		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:

7-1-99

Ending:

6-30-00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,717	3,717		3,717	37,288	41,005			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,440	28,440		28,440	399	28,839			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			129,649	129,649		129,649	(129,649)				34
35	Rent-Equipment & Vehicles			12,068	12,068		12,068	(10,125)	1,943			35
36	Other (specify):*											36
37	TOTAL Ownership			173,874	173,874		173,874	(102,087)	71,787			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			111,664	111,664		111,664		111,664			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			111,664	111,664		111,664		111,664			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,335,646	259,599	581,696	2,176,941		2,176,941	(106,151)	2,070,790			45

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

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0027078

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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	OHF 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	(4,046)	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	(18)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,064)		\$	30

OHF 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	(102,087)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (102,087)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (106,151)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Park Lawn Center

ID# 0027078

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Allowable Depreciation from Related Party	\$ 27,288	30	1
2	Allowable Interest from Related Party	399	32	2
3	Rent- Facility & Grounds	(129,649)	34	3
4	Rent- Equipment & Vehicles	(18,125)	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				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(102,087)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center# 0027078 Report Period Beginning:

7-1-99

Ending:

6-30-00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	(18)	0	0	0	0	0	0	0	0	0	0	(18)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(4,046)	0	0	0	0	0	0	0	0	0	0	(4,046)	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	(4,064)	0	0	0	0	0	0	0	0	0	0	(4,064)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,064)	0	0	0	0	0	0	0	0	0	0	(4,064)	29

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Summary B

Facility Name & ID Number Park Lawn Center# 0027078 Report Period Beginning:

7-1-99 Ending:

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	37,288	0	0	0	0	0	0	0	0	0	0	37,288 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	399	0	0	0	0	0	0	0	0	0	0	399 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	(129,649)	0	0	0	0	0	0	0	0	0	0	(129,649) 34
35	Rent-Equipment & Vehicles	(10,125)	0	0	0	0	0	0	0	0	0	0	(10,125) 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(102,087)	0	0	0	0	0	0	0	0	0	0	(102,087) 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)	(106,151)	0	0	0	0	0	0	0	0	0	0	(106,151) 45

Facility Name & ID Number Park Lawn Center

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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, Inc. See explanation on page 5A	N/A	\$	\$	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.

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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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Central Office - 10833 S. LaPorte Avenue occupies 1717 square feet Administration				\$	\$		\$	1
2	and Accounting and Bookkeeping. This is 6.96% of Total Square footage 24,693.								2
3									3
4	These costs are collected in a temporary cost center and distributed out to each								4
5	program on the basis of a predetermined, appropriated distribution by our service bureau.								5
6									6
7	Administrative salaries are distributed as follows:								7
8	1. Executive Director - % of Budget								8
9	2. Acct/Bkcp - % of Budget								9
10	3. P/R Personnel - % of Staff								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:

7-1-99

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6-30-00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	Old Kent		X	Mortgage		2-83	\$ 560,000	\$			\$	1							
2	Founders			1997 Intl Harvester	\$769.88	2-2-97	37,873	13,571	1-28-02	8.0000	1,428	2							
3				1997 Ford Truck Clubwagon	\$543.82	12-8-96	26,413	8,555	10-8-01	8.5000	986	3							
4				1996 Mercury Sable	\$410.31	11-17-96	19,929	6,089	09-17-01	8.5000	714	4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$1,724.01		\$ 644,215	\$ 28,215			\$ 3,128	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 644,215	\$ 28,215			\$ 3,128	15							

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number Park Lawn Center# 0027078 Report Period Beginning: 7-1-99 Ending: 6-30-00

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 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 2000 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 used previously to calculate a payment rate. 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 19 _____ 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:	1995 _____ 8	
	1996 _____ 9	
	1997 _____ 10	
	1998 _____ 11	
	1999 _____ 12	
		FOR OFF USE ONLY
		13 FROM R. E. TAX STATEMENT FOR 1999 \$ 13
		14 PLUS APPEAL COST FROM LINE 5 \$ 14
		15 LESS REFUND FROM LINE 6 \$ 15
		16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

Facility Name & ID Number Park Lawn Center# 0027078 Report Period Beginning:7-1-99 Ending:6-30-00**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 14,920 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/AF. 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 6-30-88 2. Number of Years Over Which it is Being Amortized: _____

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facilities</u>	<u>124,955</u>	<u>1981</u>	<u>\$ 190,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	124,955		\$ 190,000	3

Facility Name & ID Number Park Lawn Center# 0027078

Report Period Beginning:

7-1-99

Ending:

6-30-00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF 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	\$	\$ 106,636	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing Heat & AC		1982		165,500	4,729	35	4,729			9
10	Electric & Fixtures		1982		81,400	2,326	35	2,326			10
11	Elevator		1982		33,385	954	35	954			11
12	Concrete		1982		43,171	1,233	35	1,233			12
13	Sprinklers		1982		22,085	631	35	631		301,711	13
14	Bath Access.		1982		2,450	70	35	70			14
15	Construction Int		1982		18,357	525	35	525			15
16	Carpentry		1982		23,800	680	35	680			16
17	Windows		1982		33,088	945	35	945			17
18	Ceramic Tile		1982		10,621	303	35	303			18
19	Painting		1982		10,166	290	35	290			19
20	Various Construction Materials		1982		75,966	2,170	35	2,170			20
21	Permits		1982		1,803	52	35	52			21
22	Architect Fee		1982		29,577	844	35	844			22
23	Construction Manager		1982		40,000	1,143	35	1,143			23
24	Demolition		1982		6,858	196	35	196			24
25	Windows		1983		4,258	171	25	171		2,896	25
26	Sewer & Sump Pump		1983		4,933		10			4,933	26
27	Humidifer		1985		2,850		10			2,850	27
28	Parking Lot Paving		1983		700		15			700	28
29	Windows		1986		850	34	25	34		484	29
30	Generator		1986		15,785	789	20	789		11,452	30
31	Paving		1986		5,150		5			5,150	31
32	Fence/Gate		1993		2,053	205	10	205		1,624	32
33	Armstrong Floor		1994		11,000	1,100	10	1,100		7,333	33
34	Roof Repair		1997		26,382	1,759	15	1,759		6,889	34
35											35
36	TOTAL (lines 4 thru 35)				\$ 882,188	\$ 27,149		\$ 27,149	\$	\$ 452,658	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.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 103,546	\$ 9,780	\$ 9,780	\$	various	\$ 56,066	37
38	Current Year Purchases							38
39	Fully Depreciated Assets	71,957					71,957	39
40								40
41	TOTALS	\$ 175,503	\$ 9,780	\$ 9,780	\$		\$ 128,023	41

D. Vehicle Depreciation (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	
42	See attached listing . Small % of many vehicles are used for program			\$ 392,123	\$ 4,076	\$ 4,076	\$		\$ 327,872	42
43										43
44										44
45										45
46	TOTALS			\$ 392,123	\$ 4,076	\$ 4,076	\$		\$ 327,872	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,639,814	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 41,005	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 41,005	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 908,553	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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: 7-1-99

Ending: 6-30-00

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 Date of Lease	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 7-1-99

Ending 6-30-00

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

Fiscal Year Ending Annual Rent

12. 06/30/2001 \$ 129,749

13. 06/30/2002 \$ 129,749

14. 06/30/2003 \$ 129,749

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: \$ 1,943 Description: Pagers \$140, Mobile Radios \$710, Pace Vehicles \$1093 included in Schedule V line 35

(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 Schedule</u>		\$ <u>292.73</u>	\$ <u>3,513</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>292.73</u>	\$ <u>3,513</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 NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES 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 AIDE <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 AIDE <u>80 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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	0
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	0
TOTAL TRAINED	17

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	Exceptional Care Program									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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning: 7-1-99

Ending:

6-30-00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-00

(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	\$	\$ 148,600	1
2 Cash-Patient Deposits		19,618	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			6
7 Other Prepaid Expenses		11,798	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Tuition, Medicaid & Pledges		991,524	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 1,171,540	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		16,991	15
16 Equipment, at Historical Cost		399,166	16
17 Accumulated Depreciation (book methods)		(290,681)	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)	\$	\$ 125,476	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 1,297,016	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$	\$ 334,886	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits		21,000	28
29 Short-Term Notes Payable		1,670	29
30 Accrued Salaries Payable		312,694	30
31 Accrued Taxes Payable (excluding real estate taxes)		55,587	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 Misc.		33,313	36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 759,150	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 Equipment & Lease Fee		408,964	43
44 Loan Payable		124,000	44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 532,964	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 1,292,114	46
47 TOTAL EQUITY(page 18, line 24)	\$ 4,902	\$ 4,902	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,902	\$ 1,297,016	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,778	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,778	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	7,473	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) Bogard Program Income Not Residential	3,122	15
16	Other (describe) Less Unallowed Depreciation Acquis. Grant	(7,471)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,124	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)	\$ 4,902	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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,972,111	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,972,111	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	Nurses Aide Training Reimbursements		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)	\$	23
D. Non-Operating Revenue			
24	Contributions	212,121	24
25	Interest and Other Investment Income***	182	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 212,303	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)	\$ 2,184,414	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	420,656	31
32	Health Care	1,060,851	32
33	General Administration	409,896	33
B. Capital Expense			
34	Ownership	173,874	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	111,664	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,176,941	40
41	Income before Income Taxes (line 30 minus line 40)**	7,473	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,473	43

* 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: **7-1-99**

Ending:

6-30-00

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	261	314	\$ 6,345	\$ 20.21	1
2	Assistant Director of Nursing	1,935	2,080	44,671	21.48	2
3	Registered Nurses	3,188	3,228	52,548	16.28	3
4	Licensed Practical Nurses	4,300	4,605	75,709	16.44	4
5	Nurse Aides & Orderlies	1,826	2,002	15,547	7.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	484	565	9,504	16.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,249	3,505	41,429	11.82	14
15	Cook Helpers/Assistants	9,470	9,585	67,195	7.01	15
16	Dishwashers					16
17	Maintenance Workers	3,591	4,004	42,590	10.64	17
18	Housekeepers	5,223	5,790	51,258	8.85	18
19	Laundry	2,263	2,349	17,449	7.43	19
20	Administrator	2,070	2,339	66,973	28.63	20
21	Assistant Administrator					21
22	Other Administrative	3,933	4,376	63,318	14.47	22
23	Office Manager					23
24	Clerical	1,755	1,977	20,080	10.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,500	5,084	79,800	15.70	28
29	Resident Services Coordinator	369	411	6,850	16.67	29
30	Habilitation Aides (DD Homes)	66,048	68,800	601,316	8.74	30
31	Medical Records					31
32	Other Health C: Psychologist	64	64	4,061	63.45	32
33	Other(specify) Driver, Staff Train	3,879	4,310	69,003	16.01	33
34	TOTAL (lines 1 - 33)	118,408	125,388	\$ 1,335,646 *	\$ 10.65	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	231	\$ 4,620	L1 C3	35
36	Medical Director	36	4,500	L9 C3	36
37	Medical Records Consultant	27	945	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	26	1,330	L10a C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	65	3,251	L10a C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	16	2,450	L10C3	46
47	Audit, Computer, P/R, Data Proc. Other		10,179	L19 C3	47
48	Security Research		554	L20 C 3	48
49	TOTAL (lines 35 - 48)	401	\$ 27,829		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	277	\$ 11,075	L10 C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	277	\$ 11,075		53

Facility Name & ID Number Park Lawn Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
James Weise	Executive Director		\$ 32,786	Workers' Compensation Insurance	\$ 12,439	IDPH License Fee	\$ 200	
Julia Grounds	Prog. Serv. Dir.		15,856	Unemployment Compensation Insurance	9,628	Advertising: Employee Recruitment	2,752	
Eleanor Crumback	Res. Ser. Coord.		18,331	FICA Taxes	101,756	Health Care Worker Background Check (Indicate # of checks performed <u>55</u>)	554	
				Employee Health Insurance	68,598	Subscription & Texts	1,178	
				Employee Meals		Membership Dues	2,017	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	18	
				Employee Match TSA	3,175			
				Man Ben \$4,046 not included in total				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,973					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				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
Cocalas, Westberg, Mommsen	Data Processing		\$ 854	Not Applicable		\$	Out-of-State Travel	\$
Cocalas, Westberg, Mommsen	Audit		3,169					
ADP	Payroll		5,492					
Westerfield	Computer		664					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 10,179	TOTAL		\$	Seminar Expense See attached List	2,242
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,242

* Attach copy of IMRF notifications

**See instructions.

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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,411 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 of Public Aid during this cost report period. \$ 111,664
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? Yes 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 of Public Aid, 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? _____
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. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Detail of Other Lines over \$1,000 Page 3

Line 7 Column 2

Waste Removal	\$18,916.00
Plant Security	<u>\$916.00</u>
	\$19,832.00

Line 15 Column 1

QMRP	\$79,800.00
Res. Serv. Coord.	\$6,850.00
Hab Aides	\$601,316.00
Trainer	<u>\$14,728.00</u>
	\$702,694.00

Explanation Notes:

Schedule V. Page 4

Line 30 Column 3 Does not include depreciation of \$7,471 on assets acquired with Capital Acquisition Grant from DMH

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

Building Depreciation	\$27,149
Vehicle Depreciation	\$2,292
Equipment Depreciation	<u>\$7,847</u>
Total Depreciation Related Party	\$37,288

Line 35 Column 8 Community Leased equipment Pagers \$140, Mobile Radios \$710 and Pace Vehicles \$1,093

Schedule VII. Part B.

Park Lawn Association, Inc.

Building Rental not allowed	(\$129,649)
Equipment and Vehicle Lease not allowed	(\$10,125)

PLS Bldg. Interest allowed \$15,651 X 1%	\$156.51	
Vehicle Interest allowed \$3,128 X 5.1%	\$159.53	
Bldg Interest \$142.93 X 57.76%	<u>\$82.56</u>	
	\$398.60	\$399 Rounded to

Depreciation: Allowed

Building	\$27,149.00
Equipment	\$7,847.00
Vehicles	<u>\$2,292.00</u>

Total Depreciation Allowed * \$37,288.00

*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 90 (\$102,087)

Schedule IX. Page 9

Line 15 \$399 is the allowable portion of program interest, see page 5 line 35

Schedule XI. Part C.

Line 37 is \$500 less than last year due to disposition of asset during the year.

Schedule XI. Part D

Line 46 Column 5 Includes only the program portion of depreciation costs on vehicles.

Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to

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

These vehicle lease costs are only program portion and are only for medical appointments and activities. A detailed schedule

Schedule XIII. Part B. Page 15

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

Schedule XVII. Page 19 Line 41 and 43

Unallowed Depreciation on Capital Acquisition Grant of \$7,471

Schedule XVIII. Page 20 Line 33

Drivers	\$54,275.00
Trainer	\$14,728.00
	<u>\$69,003.00</u>

› any one location, so costs are assigned on a percentage basis.

› any one location, so costs are assigned on a percentage basis.
le of proration is attached.