

Facility Name & ID Number Park Lawn Home# 0035527 Report Period Beginning: 7-1-03 Ending: 6-30-04

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>15</u>	ICF/DD 16 or Less	<u>15</u>	<u>5,490</u>	6
7	<u>15</u>	TOTALS	<u>15</u>	<u>5,490</u>	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,056</u>			<u>5,056</u>	13
14	TOTALS	<u>5,056</u>			<u>5,056</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.09%

D. How many bed-hold days during this year were paid by Public Aid?

434 (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/AF. Does the facility maintain a daily midnight census? Yes

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

YES NO

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

YES NO

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

Date started 12/31/91

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

YES Date _____ NO

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/04 Fiscal Year: 06/30/04

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

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-03 Ending: 6-30-04

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	5,853	95	880	6,828	6,828		6,828		1	
2	Food Purchase		29,809		29,809	29,809		29,809		2	
3	Housekeeping		1,925		1,925	1,925		1,925		3	
4	Laundry		1,107		1,107	1,107		1,107		4	
5	Heat and Other Utilities			1,284	1,284	1,284	9,873	11,157		5	
6	Maintenance	23,148	2,673	1,693	27,514	27,514	19,133	46,647		6	
7	Other (specify):*		877		877	877		877		7	
8	TOTAL General Services	29,001	36,486	3,857	69,344	69,344	29,006	98,350		8	
	B. Health Care and Programs										
9	Medical Director			1,895	1,895	1,895		1,895		9	
10	Nursing and Medical Records	15,112	3,858	1,395	20,365	20,365		20,365		10	
10a	Therapy			690	690	690		690		10a	
11	Activities		1,046		1,046	1,046		1,046		11	
12	Social Services	7,261			7,261	7,261		7,261		12	
13	Nurse Aide Training									13	
14	Program Transportation	5,990	3,001	2,024	11,015	11,015		11,015		14	
15	Other (specify):* QMRP, Psyc., Hab, R	288,082		412	288,494	288,494		288,494		15	
16	TOTAL Health Care and Programs	316,445	7,905	6,416	330,766	330,766		330,766		16	
	C. General Administration										
17	Administrative	17,569			17,569	17,569	17,993	35,562		17	
18	Directors Fees									18	
19	Professional Services			3,761	3,761	3,761		3,761		19	
20	Dues, Fees, Subscriptions & Promotions			3,448	3,448	3,448	(16)	3,432		20	
21	Clerical & General Office Expenses	30,888	12,855		43,743	43,743		43,743		21	
22	Employee Benefits & Payroll Taxes			65,434	65,434	65,434	(375)	65,059		22	
23	Inservice Training & Education			1,045	1,045	1,045		1,045		23	
24	Travel and Seminar			33	33	33		33		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			2,317	2,317	2,317	10,299	12,616		26	
27	Other (specify):*									27	
28	TOTAL General Administration	48,457	12,855	76,038	137,350	137,350	27,901	165,251		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	393,903	57,246	86,311	537,460	537,460	56,907	594,367		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 Home

#0035527

Report Period Beginning:

7-1-03

Ending:

6-30-04

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			995	995		995	39,270	40,265			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,312	1,312		1,312	56,165	57,477			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			13,407	13,407		13,407		13,407			34
35	Rent-Equipment & Vehicles			19,403	19,403		19,403		19,403			35
36	Other (specify):*											36
37	TOTAL Ownership			35,117	35,117		35,117	95,435	130,552			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			33,600	33,600		33,600		33,600			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			33,600	33,600		33,600		33,600			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	393,903	57,246	155,028	606,177		606,177	152,342	758,519			45

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

Facility Name & ID Number Park Lawn Home

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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	(375)	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	(16)	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)	\$ (391)		\$	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	152,733	5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 152,733		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 152,342		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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Allowable Related Party Utilities	\$ 9,873	5	1
2	Allowable Related Party Maintenance	19,133	6	2
3	Allowable Administrative	17,993	17	3
4	Allowable Related Party Insurance	10,299	26	4
5	Allowable Related Party Depreciation PLH	38,165	30	5
6	Allowable Related Party Interest PLH	56,015	32	6
7	Allowable Related Party Interest PLA	150	32	7
8	Allowable Related Party Depreciation PLA	1,105	30	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	152,733		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning:

7-1-03

Ending:

6-30-04

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	9,873	0	0	0	0	0	0	0	0	0	0	9,873	5
6	Maintenance	19,133	0	0	0	0	0	0	0	0	0	0	19,133	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	29,006	0	0	0	0	0	0	0	0	0	0	29,006	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	17,993	0	0	0	0	0	0	0	0	0	0	17,993	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	(16)	0	0	0	0	0	0	0	0	0	0	(16)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(375)	0	0	0	0	0	0	0	0	0	0	(375)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	10,299	0	0	0	0	0	0	0	0	0	0	10,299	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	27,901	0	0	0	0	0	0	0	0	0	0	27,901	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	56,907	0	0	0	0	0	0	0	0	0	0	56,907	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Home

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	39,270	0	0	0	0	0	0	0	0	0	0	39,270	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	56,165	0	0	0	0	0	0	0	0	0	0	56,165	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	95,435	0	95,435	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)	152,342	0	152,342	45									

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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.	Oak Lawn	Support Org. of PL
				Park Lawn Homes, In	Alsip	

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

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

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-03 Ending: 6-30-04

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Park Lawn Home

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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 1,717 square feet for Administration				\$	\$		\$	1
2	and Accounting & 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 programs on the								4
5	basis of a predetermined, appropriated distribution.								5
6									6
7	Administrative salaries are distributed as follows:								7
8	1. Executive Director - % of Budget								8
9	2. Acct/Bkkp - % 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

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	Hinsdale Bank		2002 Mercury Sable	\$394.71	01/01/03	\$ 20,662	\$ 15,047	01/01/08	5.5000	\$ 942	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related			\$394.71		\$ 20,662	\$ 15,047			\$ 942	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 20,662	\$ 15,047			\$ 942	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
1999	_____	8		
2000	_____	9		
2001	_____	10		
2002	_____	11		
2003	_____	12		
Exempt				
			FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2003	\$		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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035527

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 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 2003.

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

B. Real Estate Tax Cost Allocation:

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

If YES, attach an explanation & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

Facility Name & ID Number Park Lawn Home

0035527 Report Period Beginning:

7-1-03 Ending:

6-30-04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,524 B. General Construction Type: Exterior Concrete Frame Aluminum gutter, dow Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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: _____ 2. Number of Years Over Which it is Being Amortized: _____

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Living Facility</u>	<u>77,381</u>	<u>1988</u>	<u>\$ 77,042</u>	1
2					2
3	TOTALS	<u>77,381</u>		<u>\$ 77,042</u>	3

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning:

7-1-03

Ending:

6-30-04

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15			1991	\$ 676,975	\$ 27,079	25	\$ 27,079	\$	\$ 339,126	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1995	18,306	732	25	732		6,651	9
10	Door East Side			2001	950	63	15	63		189	10
11	Bathroom Floor Tile			2001	625	42	15	42		150	11
12	Vinyl Flooring			2002	15,657	1,565	10	1,565		3,261	12
13	Storm Sewer			2002	3,780	378	10	378		787	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

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning:

7-1-03

Ending:

6-30-04

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	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	TOTAL (lines 4 thru 69)	\$	716,293	\$	29,859	\$	29,859	\$	350,164	70

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-03 Ending: 6-30-04

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	
71	Purchased in Prior Years	\$ 82,288	\$ 9,392	\$ 9,392	\$	5/7/2010	\$ 56,574	71
72	Current Year Purchases	1,686	181	181			181	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 83,974	\$ 9,573	\$ 9,573	\$		\$ 56,755	75

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	
76	See attached listing Page 24 A small % of a few vehicles			\$ 430,203	\$ 833	\$ 833	\$	5	\$ 319,704	76
77										77
78										78
79										79
80	TOTALS			\$ 430,203	\$ 833	\$ 833	\$		\$ 319,704	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,307,512	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 40,265	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 40,265	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)	\$ 726,623	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park Lawn Home # 0035527 Report Period Beginning: 7-1-03 Ending: 6-30-04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

**

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

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

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

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: \$ 1,792 Description: Bottled Water Rental 103, Pagers 198, PACE 790, Copier 631, Time Clock 70
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See attached listing Page 25</u>		\$ <u>66.17</u>	\$ <u>794</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>66.17</u>	\$ <u>794</u>	21

10. Effective dates of current rental agreement:

Beginning 07/01/03

Ending 06/30/04

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

Fiscal Year Ending Annual Rent

12. 06/30/2005 \$ 22,698

13. 06/30/2006 \$ 22,698

14. 06/30/2007 \$ 22,698

* 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?</p> <p><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>90 OJT</u></p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning: 7-1-03

Ending:

6-30-04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-04

(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	\$	\$ 546,803	1
2	Cash-Patient Deposits		30,154	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,146	5
6	Prepaid Insurance		44,840	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		467,147	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 1,091,090	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		506,159	16
17	Accumulated Depreciation (book methods)		(363,531)	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)	\$	\$ 142,628	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 1,233,718	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 310,055	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		30,154	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		275,657	30
31	Accrued Taxes Payable (excluding real estate taxes)		4,555	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Reserves</u>		6,728	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 627,149	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	<u>Equipment & Lease Fees</u>		515,551	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 515,551	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 1,142,700	46
47	TOTAL EQUITY(page 18, line 24)	\$ 91,018	\$ 91,018	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 91,018	\$ 1,233,718	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,902	1
2	Restatements (describe):		2
3	Net Income FY02-03 Other Programs inadvertently omitted	27,002	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,904	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,003	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) <u>Net Income Other Programs</u>	54,111	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 59,114	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)	\$ 91,018	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning: 7-1-03

Ending:

6-30-04

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	\$ 582,881	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 582,881	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	883	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)	\$ 883	23
D. Non-Operating Revenue			
24	Contributions	27,416	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,416	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)	\$ 611,180	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	69,344	31
32	Health Care	330,766	32
33	General Administration	137,350	33
B. Capital Expense			
34	Ownership	35,117	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	33,600	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 606,177	40
41	Income before Income Taxes (line 30 minus line 40)**	5,003	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,003	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 Home

0035527

Report Period Beginning:

7-1-03

Ending:

6-30-04

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	164	208	\$ 5,460	\$ 26.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	460	460	9,652	20.98	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					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	200	382	7,261	19.01	11
12	Dietician					12
13	Food Service Supervisor	406	446	5,853	13.12	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,198	1,604	23,148	14.43	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	387	439	17,569	40.02	20
21	Assistant Administrator					21
22	Other Administrative	1,405	1,713	30,888	18.03	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,268	1,620	28,977	17.89	28
29	Resident Services Coordinator	888	1,031	26,827	26.02	29
30	Habilitation Aides (DD Homes)	17,181	21,332	226,119	10.60	30
31	Medical Records					31
32	Other Health Ca Psych	23	23	1,849	80.39	32
33	Other(specify) Drivers&Trainer	763	1,010	10,300	10.20	33
34	TOTAL (lines 1 - 33)	24,343	30,268	\$ 393,903 *	\$ 13.01	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	44	\$ 880	1-3	35
36	Medical Director	15	1,895	9-3	36
37	Medical Records Consultant	2	70	10-3	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	14	690	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatrist	9	1,325	10-3	47
48	Audit, P/R, Data Process., Legal		3,863	19-3	48
49	TOTAL (lines 35 - 48)	84	\$ 8,723		49

C. CONTRACT NURSES

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

Facility Name & ID Number Park Lawn Home

0035527

Report Period Beginning: 7-1-03

Ending: 6-30-04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
James Weise	Executive Dir.		\$ 10,415	Workers' Compensation Insurance	\$ 5,526	IDPH License Fee	\$	
Julia Grounds	Deputy Exe. Dir.		7,154	Unemployment Compensation Insurance	4,730	Advertising: Employee Recruitment	598	
				FICA Taxes	29,614	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	23,087	Membership Dues	2,474	
				Employee Meals		Subscriptions & Texts	360	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	16	
				Employer Match TSA	2,102	License Fee Other		
				Man Ben \$ 375, not included in total				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 17,569			Less: Public Relations Expense	(16)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 65,059	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,432	
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	Audit		\$ 1,035	N/A		\$	Out-of-State Travel	\$
ADP	Payroll		1,308					
Midwest Time Recorder	Data Processing		1,370				In-State Travel	
James Himmel	Legal		48				The ARC of Illinois	33
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 3,761	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 33

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Lawn Home

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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. \$ 33,600
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? 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. 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.

D. Vehicle Depreciation

1 Use	2 Make, Model & Year	3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Program % Depre.	6 Straight Line Depr.	Program % Straight Line Dep.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation
79 Activities	93 Ford Econoline	** 1993	\$20,602.00	\$0.00			\$0.00			5	\$20,602.00
80 Activities	96 Mercury Sable	** 1996	\$19,929.00	\$0.00		\$0.00	\$0.00	\$0.00		5	\$19,929.00
81 Activities	95 Dodge Caravan	* 1996	\$34,594.00	\$0.00		\$0.00	\$0.00	\$0.00		5	\$34,594.00
83 Activities	97 Ford Club Wagon	** 1997	\$27,413.00	\$0.00			\$0.00			5	\$27,413.00
84 Activities	94 Ford Econoline PA	* 1994	\$35,416.00	\$0.00			\$0.00			5	\$35,416.00
85 Activities	96 Dodge Caravan	* 1996	\$34,594.00	\$0.00		\$0.00	\$0.00	\$0.00		5	\$34,594.00
86 Activities	97 Dodge	* 1997	\$34,995.00	\$0.00		\$0.00	\$0.00	\$0.00		5	\$34,995.00
87 Activities	96 Ford Eldorado	* 1996	\$51,286.00	\$0.00		\$0.00	\$0.00	\$0.00		5	\$51,286.00
88 Activities	99 Dodge Max Van	* 1999	\$19,094.00	\$3,659.68	3	\$109.79	\$3,659.68	\$109.79		5	\$19,094.00
89 Activities	00 Dodge Maxi Van	* 2000	\$19,977.00	\$3,995.40	3	\$119.86	\$3,995.40	\$119.86		5	\$15,814.73
90 Activities	01 Light Duty Ford Eldorado	* 2002	\$44,353.00	\$8,870.60	3	\$266.12	\$8,870.60	\$266.12		5	\$14,784.33
91 Activities	02 Mini Van Chevy Venture	* 2002	\$33,545.00	\$6,709.00	3	\$201.27	\$6,709.00	\$201.27		5	\$11,181.67
92 Activities	03 Ford Eldorado	* 2003	\$54,404.53	\$4,533.71	3	\$136.01	\$4,533.71	\$136.01		5	\$4,533.71
			\$430,202.53	\$27,768.39		\$833.05	\$27,768.39	\$833.05			\$319,703.73

* Owned by Park Lawn School Depreciation \$833.05

** Owned by Park Lawn Association Depreciation 0
833.05

Due to the number of participants transported in all Park Lawn Programs and varied routes, Park Lawn in unable to assign ane vehicle to any one location, costs are assigned on a percentage of use basis.

XII. C. Vehicle Rental

	1	2	3	Program	Program % of	4
	Use	Make, Model & Year	Monthly Lease Pymt.	% of Use	Monthly Lease	Rental Expense
						for this Period
17 Activities		93 Ford Club Wagon	\$86.00	0.7694	\$66.17	\$794.02
<hr/>						
21 Totals			\$86.00		\$66.17	\$794.02

Explanation Notes:

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

Line 7 Column 2

Waste Removal	\$492
Plant Security	<u>\$385</u>
	\$877

Line 15 Column 1

QMRP	\$28,977
Psych	\$1,849
Resident Services Coord	\$26,827
Trainer	\$4,310
Hab Aides	<u>\$226,119</u>
	\$288,082

Line 23	American Red Cross	\$106
	Armstrong Medical (CPR Supplies)	\$5
	Human Resources Council	\$17
	Illinois Health Care Assoc	\$222
	Reliable Fire Equipment	\$27
	The Arc of Illinois	\$597
	Internal Board Staff Meeting Supplies	<u>\$71</u>
		\$1,045

Schedule V, Page 3 & 4

Line 5 Column 7	Allowable Related Party Costs for Utilities	\$9,873
Line 6 Column 7	Allowable Related Party Costs for Maintenance	\$19,133
Line 17 Column 7	Allowable Related Party Costs for Administrative	\$17,993
Line 26 Column 7	Allowable Related Party Costs for Insurance	\$10,299
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLH	\$38,165
Line 30 Column 7	Allowable Related Party Costs for Depreciation PLA	\$1,105
Line 32 Column 7	Allowable Related Party Costs for Interest PLA	\$150
Line 32 Column 7	Allowable Related Party Costs for Interest PLH	<u>\$56,015</u>
		\$152,733

Total Related Party Costs

Line 34 Column 4 Includes:

Office for Park Lawn School Program	\$11,214
Equipment from Park Lawn Association	<u>\$2,193</u>
	\$13,407

Line 35 Column 4 Includes:

Vehicle Rental Park Lawn Association	\$794
Portion of Rent not in HUD Payments Park Lawn School Costs	\$13,378
Equipment Rental	\$4,441
Pace Vehicle Rental	<u>\$790</u>
	\$19,403

Schedule VII. Part B Page 6

Park Lawn Association, Inc.

Depreciation of Vehicles		\$0
Interest on Vehicles 942 X 3%	\$28	
PLS Interest 5170.34 X .0235%	\$122	
Depreciation Bldg & Equipment	\$1,105	
		<u>\$1,255</u>
Total Park Lawn Association Costs		\$1,255

Park Lawn Homes, Inc.

Utilities	\$9,873
Maintenance	\$19,133
Administration	\$17,993
Taxes/Insurance	\$10,299
Interest	\$56,015
Depreciation Bldg. & Equipment	<u>\$38,165 *</u>
Total Park Lawn Homes Costs	\$151,478

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

Total Related Party Adjustment on Page 5A Line 49 \$152,733

Schedule IX. Page 9

Line 15 \$28 is the allowable portion of program interest, see page 5 line 35

Schedule XI. Part D. Page 13

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

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 costs are only the program portion and are only for activities. A detail schedule of proration is attached on page 25.

Schedule XIII. Part B Page 15

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

Schedule XX. Page 23

Question 12 Allocated based on hours worked per department.

Question 15 No Employee meals are served.