



Facility Name & ID Number Park Lawn Center

# 0027078 Report Period Beginning: 7-1-04 Ending: 6-30-05

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	14,532			14,532	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,532			14,532	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.11%

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

333 (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: 6/30/05 Fiscal Year: 6/30/05

\* 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: 7-1-04 Ending: 6-30-05

**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
	<b>A. General Services</b>										
1	Dietary	114,888	1,811	5,880	122,579		122,579	122,579			1
2	Food Purchase		119,771		119,771		119,771	119,771			2
3	Housekeeping	42,616	4,558		47,174		47,174	47,174			3
4	Laundry	18,480	4,474		22,954		22,954	22,954			4
5	Heat and Other Utilities			40,247	40,247		40,247	40,247			5
6	Maintenance	44,862	18,251	11,128	74,241		74,241	74,241			6
7	Other (specify):* <b>Waste Remov &amp; Plant</b>		31,208		31,208		31,208	31,208			7
8	<b>TOTAL General Services</b>	220,846	180,073	57,255	458,174		458,174	458,174			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,575	6,575		6,575	6,575			9
10	Nursing and Medical Records	211,409	39,438	33,531	284,378		284,378	284,378			10
10a	Therapy			4,058	4,058		4,058	4,058			10a
11	Activities		1,183		1,183		1,183	1,183			11
12	Social Services	5,390			5,390		5,390	5,390			12
13	CNA Training	279			279		279	279			13
14	Program Transportation	17,165	5,933	5,341	28,439		28,439	28,439			14
15	Other (specify):*	693,768		1,344	695,112		695,112	695,112			15
16	<b>TOTAL Health Care and Programs</b>	928,011	46,554	50,849	1,025,414		1,025,414	1,025,414			16
	<b>C. General Administration</b>										
17	Administrative	49,725			49,725		49,725	49,725			17
18	Directors Fees										18
19	Professional Services			18,656	18,656		18,656	18,656			19
20	Dues, Fees, Subscriptions & Promotions			7,772	7,772		7,752	(18)	7,734		20
21	Clerical & General Office Expenses	172,693		28,557	201,250		201,250	201,250			21
22	Employee Benefits & Payroll Taxes			260,328	260,328		260,328	(1,418)	258,910		22
23	Inservice Training & Education			5,858	5,858		5,834		5,834		23
24	Travel and Seminar			282	282		281		281		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			16,518	16,518		16,518		16,518		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	222,418		337,971	560,389		560,344	(1,436)	558,908		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,371,275	226,627	446,075	2,043,977		2,043,932	(1,436)	2,042,496		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:

7-1-04

Ending:

6-30-05

## 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	
	<b>D. Ownership</b>											
30	Depreciation			6,405	6,405	(3,227)	3,178	30,377	33,555			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,572	1,572		1,572	89	1,661			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			132,902	132,960		132,960	(132,902)	58			34
35	Rent-Equipment & Vehicles			14,197	14,244		14,244	(4,502)	9,742			35
36	Other (specify):* <b>Unallowed Dep Acq Grant</b>					3,227	3,227		3,227			36
37	<b>TOTAL Ownership</b>			155,076	155,181		155,181	(106,938)	48,243			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			134,044	134,044		134,044		134,044			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			134,044	134,044		134,044		134,044			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,371,275	226,627	735,195	2,333,202		2,333,157	(108,374)	2,224,783			45

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning: 7-1-04

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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	(1,418)	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	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,436)		\$	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)	(106,938)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (106,938)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (108,374)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Park Lawn Center

ID# 0027078

Report Period Beginning: 7-1-04

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Allowable Depreciation from Related Party	\$ 30,377	30	1
2	Allowable Interest from Related Party	89	32	2
3	Rent - Facility & Grounds	(132,902)	34	3
4	Rent - Equipment & Vehicles	(4,502)	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	<b>Total</b>	(106,938)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-04

Ending:

6-30-05

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)	
	<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
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	(1,418)	0	0	0	0	0	0	0	0	0	0	(1,418)	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	<b>TOTAL General Administration</b>	(1,436)	0	0	0	0	0	0	0	0	0	0	(1,436)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(1,436)	0	0	0	0	0	0	0	0	0	0	(1,436)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-04

Ending:

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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	30,377	0	0	0	0	0	0	0	0	0	0	30,377	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	89	0	0	0	0	0	0	0	0	0	0	89	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(132,902)	0	0	0	0	0	0	0	0	0	0	(132,902)	34
35	Rent-Equipment & Vehicles	(4,502)	0	0	0	0	0	0	0	0	0	0	(4,502)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(106,938)</b>	<b>0</b>	<b>(106,938)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(108,374)</b>	<b>0</b>	<b>(108,374)</b>	<b>45</b>									

Facility Name & ID Number Park Lawn Center

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Report Period Beginning:

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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 Organizati

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 explantion 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.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-04 Ending: 6-30-05

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 Center

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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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Central Office - 10833 S. Laporte Avenue occupies 1717 square feet Administration				\$	\$		\$	1
2	and Accounting and Bookkeeping. This is 6.96% of Total Square fottage 24, 693.								2
3									3
4	These costs are distributed to each program on the percentage of budget.								4
5									5
6	The Administrative salaries are distributed on the percentage of budget basis.								6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-04 Ending: 6-30-05

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Hinsdale Bank		2002 Mercury Sable	\$394.71	1/1/03	\$ 20,662	\$ 11,038	1/1/08	5.5000	\$ 728	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6											6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>			\$394.71		\$ 20,662	\$ 11,038			\$ 728	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$ 20,662	\$ 11,038			\$ 728	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.)



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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,

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Park Lawn Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027078

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2004

(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. _____	Not Applicable	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 hom (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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Park Lawn Center

# 0027078 Report Period Beginning:

7-1-04 Ending:

6-30-05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,920 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 2

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

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

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

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

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

N/A

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

1. Total Amount Incurred: Completely Amortized 6-30-88 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:**

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

Facility Name &amp; ID Number Park Lawn Center

# 0027078

Report Period Beginning:

7-1-04

Ending:

6-30-05

**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	\$	\$ 136,636	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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			13
14	Bath. Access.		1982		2,450	70	35	70			14
15	Construction Int		1982		18,357	525	35	525		386,253	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	Architech 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		3,751	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					700	28
29	Windows		1986		850	34	25	34		654	29
30	Generator		1986		15,785	789	20	789		15,397	30
31	Paving		1986		5,150		5			5,150	31
32	Fence/Gate		1993		2,053		10			2,053	32
33	Armstrong Floor		1994		11,000		10			11,000	33
34	Roof Repair		1997		26,382	1,759	15	1,759		15,684	34
35	Tile, Main Area, Floor Patch		2001		5,857	586	10	586		2,197	35
36	Compressor		2004		2,475	165	15	165		165	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 Center

# 0027078

Report Period Beginning:

7-1-04

Ending:

6-30-05

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 4 Stage Chiller	2005	\$ 1,285	\$ 79	15	\$ 79	\$	\$ 79	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)		\$ 891,805	\$ 26,674		\$ 26,674	\$	\$ 587,502	70

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-04 Ending: 6-30-05

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	\$ 31,834	\$ 4,370	\$ 4,370	\$	Various	\$ 20,178	71
72	Current Year Purchases	593	75	75		7	75	72
73	Fully Depreciated Assets	140,413					140,413	73
74								74
75	TOTALS	\$ 172,840	\$ 4,445	\$ 4,445	\$		\$ 160,666	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 on page 24. Small % of many vehicles			\$	\$	\$	\$		\$	76
77	are used for program.			394,787	2,436	2,436			319,278	77
78										78
79										79
80	TOTALS			\$ 394,787	\$ 2,436	\$ 2,436	\$		\$ 319,278	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)	\$ 1,649,432	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,555	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,555	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)	\$ 1,067,446	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.

**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	<b>TOTAL</b>				\$			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: \$ 9,695 Description: PACE 1617, Pagers 185, Copier 7893

(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>394.00</u>	\$ <u>2,567</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>394.00</u>	\$ <u>2,567</u>	21

10. Effective dates of current rental agreement:

Beginning 7-01-04

Ending 6-30-05

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

Fiscal Year Ending Annual Rent

12. 06/30/2006 \$ 129,749

13. 06/30/2007 \$ 129,749

14. 06/30/2008 \$ 129,749

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-04 Ending: 6-30-05

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

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

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

**B. EXPENSES**

ALLOCATION OF COSTS (d)

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	34
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>34</b>

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

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

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

	Service	1 Schedule V Line & Column Reference	2 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 CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning: 7-1-04

Ending:

6-30-05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 92,503	1
2	Cash-Patient Deposits		45,607	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		3,343	5
6	Prepaid Insurance		44,875	6
7	Other Prepaid Expenses		1,918	7
8	Accounts Receivable (owners or related parties)		1,170,561	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 1,358,807	10
<b>B. Long-Term Assets</b>				
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		506,150	16
17	Accumulated Depreciation (book methods)		(401,981)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 104,169	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 1,462,976	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 81,559	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		45,606	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		286,776	30
31	Accrued Taxes Payable (excluding real estate taxes)		2,547	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
<b>Other Current Liabilities(specify):</b>				
36	<u>Reserves</u>		7,239	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 423,727	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Equipment &amp; Lease Fees</u>		948,232	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 948,232	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 1,371,959	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 91,018	\$ 91,017	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 91,018	\$ 1,462,976	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>91,018</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>91,018</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)		<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>91,018</b>	<b>24</b> *

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

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning: 7-1-04

Ending:

6-30-05

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,245,099	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,245,099	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	41,322	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 41,322	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	46,784	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 46,784	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,333,205	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	458,174	31
32	Health Care	1,025,414	32
33	General Administration	560,389	33
<b>B. Capital Expense</b>			
34	Ownership	155,181	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	134,044	36
<b>D. Other Expenses (specify):</b>			
37	<u>Rounding</u>	3	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,333,205	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>		41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$	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:

7-1-04

Ending:

6-30-05

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,560	1,840	\$ 48,786	\$ 26.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,240	4,626	97,154	21.00	3
4	Licensed Practical Nurses	2,961	3,434	61,816	18.00	4
5	CNAs & Orderlies	368	411	3,653	8.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	195	276	5,390	19.53	11
12	Dietician					12
13	Food Service Supervisor	1,155	1,600	23,632	14.77	13
14	Head Cook	2,912	3,440	33,847	9.84	14
15	Cook Helpers/Assistants	6,233	7,655	57,409	7.50	15
16	Dishwashers					16
17	Maintenance Workers	3,116	3,265	44,862	13.74	17
18	Housekeepers	3,291	4,114	42,616	10.36	18
19	Laundry	2,034	2,403	18,480	7.69	19
20	Administrator	861	1,088	49,725	45.70	20
21	Assistant Administrator					21
22	Other Administrative	5,702	7,205	156,867	21.77	22
23	Office Manager	1,154	1,319	15,826	12.00	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,421	5,868	82,447	14.05	28
29	Resident Services Coordinator	605	733	22,189	30.27	29
30	Habilitation Aides (DD Homes)	53,385	63,266	553,487	8.75	30
31	Medical Records					31
32	Other Health Ca Psych	68	68	5,344	78.59	32
33	Other(specify) Driver/FSA/Traine	3,595	4,549	47,745	10.50	33
34	TOTAL (lines 1 - 33)	98,856	117,160	\$ 1,371,275 *	\$ 11.70	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	294	\$ 5,880	1-3	35
36	Medical Director	53	6,575	9-3	36
37	Medical Records Consultant	19	665	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	7	280	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	67	3,658	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	31	5,500	10-3	46
47	P/R, Data Processing, Audit		16,565	19-3	47
48	Legal		2,091	19-3	48
49	TOTAL (lines 35 - 48)	471	\$ 41,214		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	79	\$ 4,086	10-3	50
51	Licensed Practical Nurses	676	23,000	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	755	\$ 27,086		53

Facility Name & ID Number Park Lawn Center

# 0027078

Report Period Beginning: 7-1-04

Ending: 6-30-05

**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.		\$ 34,452	Workers' Compensation Insurance	\$ 31,065	IDPH License Fee	\$ 4,781	
Julia Grounds	Deputy Exec. Dir.		15,273	Unemployment Compensation Insurance	22,350	Advertising: Employee Recruitment	409	
				FICA Taxes	102,072	Health Care Worker Background Check (Indicate # of checks performed <u>41</u> )		
				Employee Health Insurance	100,458	Other Liscense Fees	75	
				Employee Meals		Membership Dues	2,282	
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions & Texts	187	
				Employer Match TSA	2,965	Public Relations	18	
				Man Ben \$1,418 not included in total				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,725			Less: Public Relations Expense	(18)	
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)			\$					
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		\$ 3,286	N/A			Out-of-State Travel	\$
ADP	Payroll		7,960					
Cipher	Data Processinsg		5,319				In-State Travel	
	Legal		2,091					
							Seminar Expense	
							The ARC of Illinois	282
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 18,656	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 282

\* 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. \$ 9,314 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,044  
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, 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.

1 Use	2 Make, Model & Year	3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Prog. % of Depreciation	6 Straight Line Depreciation	Program % of Straight Line Depr.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation	
79 Medical Appts.	93 Ford Econoline	**	1993	\$20,602.00	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$20,602.00
80 Medical Appts.	96 Mercury Sable	**	1996	\$19,929.00	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$19,929.00
81 Medical Appts.	95 Dodge Caravan	*	1996	\$34,594.00	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$34,594.00
83 Medical Appts.	97 Ford Club Wagon	**	1997	\$27,413.00	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$27,413.00
84 Medical Appts.	96 Dodge Caravan	*	1996	\$34,594.00	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$34,594.00
85 Medical Appts.	97 Dodge	*	1997	\$34,995.00	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$34,995.00
86 Medical Appts.	96 Ford Eldorado	*	1996	\$51,286.00	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$51,286.00
87 Medical Appts.	99 Dodge Max Van	*	1999	\$19,094.00	\$3,659.68	8.775	\$321.14	\$0.00	\$321.14	-	5	\$19,094.00
88 Medical Appts.	00 Dodge Maxi Van	*	2000	\$19,977.00	\$3,995.40	8.775	\$350.60	\$3,995.40	\$350.60	-	5	\$19,810.53
89 Medical Appts.	01 Light Duty Ford Eld*		2002	\$44,353.00	\$8,870.60	8.775	\$778.40	\$8,870.60	\$778.40	-	5	\$23,654.93
90 Medical Appts.	02 Mini Van Chevy Ve*		2002	\$33,545.00	\$6,709.00	8.775	\$588.71	\$6,709.00	\$588.71		5	\$17,890.67
91 Medical Appts.	03 Ford Eldorado	*	2003	\$54,404.53	\$4,533.71	8.775	\$397.83	\$10,881.00	\$397.83		5	\$15,414.62
				\$394,786.53	\$27,768.39		\$2,436.68	\$30,456.00	\$2,436.68			\$319,277.75

\* Owned by Park Lawn School                      Depreciation     \$2,436.68

\*\* Owned by Park Lawn Assoc.                      Depreciation               \$0.00

\$2,436.68

Due to the number of Participants transported 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.

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		96 Mercury Sable Station Wagon	\$166.00	0.0189	\$3	\$37.65	2553.85
18 Activities		97 Ford Club Wagon	\$228.00	0.9245	\$211	\$2,529.43	
21 Totals			\$394.00		\$214	\$2,567.08	



Related Party Adjustment

Park Lawn  
Center

Lease Adjustment  
Management Benefits  
P/R & In Kind

ADJUSTMENT EXPLANATION  
2003/2004 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMEN	ORS	CILA	126TH ST. RESIDENTI/	115TH ST. RESIDENTIAL
Total Lease	378,033	61,290	105,802	10,419	2,338	17,986	32,994	147,204
LESS: Community Lease	41,707	6,848	15,417	2,718	58	3,020	3,951	9,695
Related Organization	336,326	54,442	90,385	7,701	2,280	14,966	29,043	137,509
Interest & Depreciation Related Organization	294,534	23,148	71,850	6,747	2,302	67,067	92,954	30,466
Adjustment	(41,792)	(31,294)	(18,535)	(954)	22	52,101	63,911	(107,043)
Adjust Related Organization	294,534	23,148	71,850	6,747	2,302	67,067	92,954	30,466
Community Lease	41,707	6,848	15,417	2,718	58	3,020	3,951	9,695
Grand Total Allowable Lease	336,241	29,996	87,267	9,465	2,360	70,087	96,905	40,161
Other Adjustments								
Management Benefits	(3,905)	(411)	(604)	(73)	0	(984)	(415)	(1,418)
Public Relations	(7,931)	(146)	(7,506)	(81)	(163)	(12)	(5)	(18)
In Kind	0	0	0	0	0	0	0	0
Total Interest	PLA 74,083.00	PLH 55,603.00						
Total Depreciation	149,815.00	36,843.00						
	223,898.00	92,446.00						
PLH	92,446.00							
	316,344.00							
Fundraising	-21,811.00							
	294,533.00							

PLA Depreciation  
Bldg. Depreciation 112,358.00  
Equipment Depreciation 37,457.00  
149,815.00

Mortgage Interest 73,356.00  
Vehicle Interest 727  
74,083.00

Equipment	Year of Acquisition	Cost	Public Aid Line Depreciation	Life in Years	Public Aid Straight Line Depreciation
Various Equipment	1983-1987	\$34,918.53	15	\$0.00	Fully Depreciated
Various Equipment	1983-1987	\$40,012.19	20	\$0.00	Fully Depreciated
		\$74,930.72			\$0.00
<b>EQUIPMENT 9847</b>					
Bedding	1987	\$203.00	3	\$0.00	Fully Depreciated
Rug Shampooer	1987	\$1,300.00	5	\$0.00	Fully Depreciated
		\$1,503.00			\$0.00
<b>EQUIPMENT 9849</b>					
Tile Floor	1989	\$1,476.00	20	\$0.00	Fully Depreciated
Carpeting	1989	\$1,410.00	7	\$0.00	Fully Depreciated
		\$2,886.00			\$0.00
<b>EQUIPMENT 9850</b>					
Time Clock	1990	\$1,100.00	7	\$0.00	Fully Depreciated
Card Rack	1990	\$75.00	10	\$0.00	Fully Depreciated
Carpeting	1990	\$4,931.00	5	\$0.00	Fully Depreciated
		\$6,106.00			\$0.00
<b>EQUIPMENT 9851</b>					
Insulated Heated Cabinet	1991	\$1,392.00	10	\$0.00	Fully Depreciated
		\$1,392.00			\$0.00
<b>EQUIPMENT 9192</b>					
Mattresses	1991	\$1,196.00	5	\$0.00	Fully Depreciated
Decks (2)	1991	\$607.00	5	\$0.00	Fully Depreciated
Decks (2)	1991	\$143.00	5	\$0.00	Fully Depreciated
13 inch TV	1991	\$80.00	5	\$0.00	Fully Depreciated
Portable Scale	1992	\$365.00	5	\$0.00	Fully Depreciated
Urns - Stainless Hinges	1992	\$195.00	5	\$0.00	Fully Depreciated
Sand Urns (3)	1992	\$101.00	5	\$0.00	Fully Depreciated
Table Lamp	1992	\$97.00	5	\$0.00	Fully Depreciated
Revolving Couch/Chair	1992	\$1,703.00	5	\$0.00	Fully Depreciated
Table (Wood)	1992	\$100.00	5	\$0.00	Fully Depreciated
Rubber Rocker Chair	1992	\$100.00	5	\$0.00	Fully Depreciated
Reverer	1992	\$100.00	5	\$0.00	Fully Depreciated
Walker - Aluminum	1992	\$75.00	5	\$0.00	Fully Depreciated
		\$4,712.00			\$0.00
<b>EQUIPMENT 0293</b>					
Teaset	1993	\$500.00	5	\$0.00	Fully Depreciated
19" TV	1993	\$50.00	5	\$0.00	Fully Depreciated
File Cabinets	1993	\$934.00	5	\$0.00	Fully Depreciated
Chairs	1993	\$770.00	5	\$0.00	Fully Depreciated
Vacuums	1993	\$253.00	5	\$0.00	Fully Depreciated
Lithonary Tool	1993	\$180.00	5	\$0.00	Fully Depreciated
Wash Cars	1993	\$257.00	5	\$0.00	Fully Depreciated
Air Compressor	1993	\$270.00	5	\$0.00	Fully Depreciated
Word Processor	1993	\$100.00	5	\$0.00	Fully Depreciated
Lockers	1993	\$146.00	5	\$0.00	Fully Depreciated
Mattresses (8)	1993	\$450.00	5	\$0.00	Fully Depreciated
Vertical Blinds	1993	\$276.00	5	\$0.00	Fully Depreciated
Intercom	1993	\$59.00	5	\$0.00	Fully Depreciated
		\$3,442.00			\$0.00
<b>EQUIPMENT 0394</b>					
Vertical Blinds	1994	\$3,883.00	7	\$0.00	Fully Depreciated
Waiting Machine	1994	\$434.00	5	\$0.00	Fully Depreciated
Chair/Table	1994	\$588.00	5	\$0.00	Fully Depreciated
Flood Light	1994	\$304.00	5	\$0.00	Fully Depreciated
Garbage Cans (Snap On)	1994	\$444.00	5	\$0.00	Fully Depreciated
Laundry Cart	1994	\$137.00	5	\$0.00	Fully Depreciated
Ejector Pump	1994	\$278.00	5	\$0.00	Fully Depreciated
Printer	1994	\$238.00	5	\$0.00	Fully Depreciated
		\$6,364.00			\$0.00
<b>EQUIPMENT 9495</b>					
Sofa, Love Seat, Chairs, Tables	1995	\$3,395.00	10	\$0.00	Fully Depreciated
Lumex Bath Seat	1995	\$124.00	5	\$0.00	Fully Depreciated
Box Springs (2)	1995	\$2,880.00	5	\$0.00	Fully Depreciated
TV Cabinets (2)	1995	\$838.00	5	\$0.00	Fully Depreciated
Magnavox VCR	1995	\$260.00	5	\$0.00	Fully Depreciated
Bookcases (2)	1995	\$1,200.00	5	\$0.00	Fully Depreciated
Microwave (Classier)	1995	\$779.00	5	\$0.00	Fully Depreciated
Tablers (Remote Control)	1995	\$51.00	5	\$0.00	Fully Depreciated
Chair (3)	1995	\$300.00	5	\$0.00	Fully Depreciated
		\$8,247.00			\$0.00
<b>EQUIPMENT 9596</b>					
Chairs (10)	1996	\$337.00	10	\$34.00	
Chair	1996	\$119.00	10	\$12.00	
Oak Chairs	1996	\$2,164.00	10	\$216.00	
Lamps	1996	\$404.00	10	\$40.00	
Felice	1996	\$388.00	10	\$38.79	
Soap Dispensers	1996	\$325.00	10	\$33.00	
Ice Cola Maker	1996	\$2,030.00	7	\$0.00	Fully Depreciated
Dryer, Gas	1996	\$394.00	7	\$0.00	Fully Depreciated
Wescomal Dryer	1996	\$9,089.00	7	\$0.00	Fully Depreciated
		\$18,230.00			\$373.79
<b>EQUIPMENT 9697</b>					
Defi Compute	1997	\$2,295.00	10	\$230.00	
Mustang Scrubber	1997	\$1,370.00	10	\$137.00	
Two Gilbane	1997	\$1,600.00	10	\$160.00	
		\$5,265.00			\$527.00
<b>EQUIPMENT 9798</b>					
Stereo	1998	\$673.00	7	\$32.00	Fully Depreciated
2 Dell Computers	1998	\$6,429.00	10	\$642.90	
		\$7,102.00			\$674.90
<b>EQUIPMENT 9899</b>					
2 Chairs	1999	\$2,599.00	10	\$260.00	
<b>EQUIPMENT 0001</b>					
NO NEW EQUIPMENT					
<b>EQUIPMENT 0001</b>					
Hot Water Heater	2001	\$4,280.00	20	\$214.00	
<b>EQUIPMENT 0102</b>					
NO NEW EQUIPMENT					
<b>EQUIPMENT 0203</b>					
Access Exam Table	2002	\$1,354.81	7	\$194.00	
<b>EQUIPMENT 0304</b>					
Seat & Back Cushions	2003	\$1,818.75	7	\$259.96	
Total PLA Equipment/Depreciation		\$158,252.08		\$2,805.75	
<b>Bank Lines School &amp; Adult Center</b>					
<b>EQUIPMENT 9697</b>					
Phone System	1996	\$5,137.00	5	\$0.00	Fully Depreciated
Wet Dry Vacuum	1996	\$528.00	5	\$0.00	Fully Depreciated
		\$5,665.00			\$0.00
<b>EQUIPMENT 0102</b>					
Accounting Software (Program %)	2001	\$2,977.11	5	\$595.42	
<b>EQUIPMENT 0203</b>					
Accounting Software (Program %)	2003	\$352.23	5	\$70.45	
<b>EQUIPMENT 0405</b>					
Human Resource Desk Furniture (Program %)	2004	\$933.30	7	\$75.46	
Total P.L.A. Equipment/Depreciation		\$13,567.64		\$741.53	
Total Equipment Both Corporations		\$172,839.72		\$1,547.28	
Total Depreciation Both Corporations				\$1,547.28	

Explanation Notes:

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

Line 7 Column 2

Waste Removal	\$31,121
Plant Security	\$87
	<u>\$31,208</u>

Line 15 Column 1

QMRP	\$82,447
Res. Serv. Coord.	\$22,189
Hab. Aides	\$553,487
Facility Service Aide	\$30,301
Psychiatrist	\$5,344
	<u>\$693,768</u>

Schedule V. Page 4

Line 30 Column 5 To move depreciation of \$3,227 on assets acquired with Capital Acquisition Grant from DMH which is unallowed so it won't be included in depreciation number that we need to tie to.

Line 36 Column 5 Unallowed Capital Acquisition Grant Depreciation identified

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

Page 28-2

Building Depreciation Admin Office 7381.75 X	\$591.00
Equipment Depreciation Admin 8437.78 X .03	\$306.00
Building Depreciation	\$26,674.00
Equipment Depreciation	<u>\$2,806.00</u>
	\$30,377.00

Line 35 Column 8 Community Leased equipment: Pagers \$185, Copier \$7,893, PACE \$1,617

Schedule VII. Part B

Park Lawn Association, Inc.	
Building Rental not allowed	(\$132,902)
Equipment Rental not allowed	(\$4,502)

Vehicle Interest Allowed \$728 X 12.0%	<u>\$89</u>	\$89
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Depreciation Allowed	
Building Depreciation Admin Office 7381.75 X	591
Equipment Depreciation Admin 8437.78 X .03	306
Building	26,674
Equipment	<u>2,806</u>

Total Depreciation Allowed \* \$30,377

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

Total Related Party Adjustment Detailed on Page 5A line 49 (\$106,938.00)

Schedule IX. Page 9

Line 15 \$484 is the allowable portion of program interest, see page 5A Line 2

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 routed, 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 lease costs are only program portion and are for activities.

A detailed schedule of proration is on Page 25.

Schedule XIII. B Page 15

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

Schedule XVIII. Page 19 Line 41 and 43

Unallowed Depreciation on Capital Acquisition Grant of \$3,227

Schedule XVIII. Page 20 Line 33

Drivers	\$17,165
Facilities Service Aide	\$30,301
Trainer	\$279
	<u>\$47,745</u>

Schedule XX. Page 23

Question 12 Allocated on basis of hours worked per department

Question 15 No Employee meals are served