

Facility Name & ID Number Park Lawn Center

0027078 Report Period Beginning: 7-1-05 Ending: 6-30-06

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	14,222			14,222	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,222			14,222	14

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

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

303 (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: 6-30-06 Fiscal Year: 6-30-06

* 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: 7-1-05 Ending: 6-30-06

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	116,240	1,300	5,040	122,580		122,580	122,580		1	
2	Food Purchase		117,130		117,130		117,130	117,130		2	
3	Housekeeping	45,699	6,148		51,847		51,847	51,847		3	
4	Laundry	15,129	5,029		20,158		20,158	20,158		4	
5	Heat and Other Utilities			51,955	51,955		51,955	51,955		5	
6	Maintenance	48,373	25,080	9,616	83,069		83,069	83,069		6	
7	Other (specify):* Waste Removal & Plant Sec		33,370		33,370		33,370	33,370		7	
8	TOTAL General Services	225,441	188,057	66,611	480,109		480,109	480,109		8	
	B. Health Care and Programs										
9	Medical Director			6,075	6,075		6,075	6,075		9	
10	Nursing and Medical Records	211,746	47,022	52,830	311,598		311,598	311,598		10	
10a	Therapy			5,953	5,953		5,953	5,953		10a	
11	Activities		1,680	199	1,879		1,879	1,879		11	
12	Social Services	5,468			5,468		5,468	5,468		12	
13	CNA Training									13	
14	Program Transportation	19,694	9,160	4,650	33,504		33,504	33,504		14	
15	Other (specify):* See Notes	733,952		6,725	740,677		740,677	740,677		15	
16	TOTAL Health Care and Programs	970,860	57,862	76,432	1,105,154		1,105,154	1,105,154		16	
	C. General Administration										
17	Administrative	55,659			55,659		55,659	55,659		17	
18	Directors Fees									18	
19	Professional Services			19,188	19,188		19,188	19,188		19	
20	Dues, Fees, Subscriptions & Promotions			18,934	18,934		18,934	(6) 18,928		20	
21	Clerical & General Office Expenses	162,015	24,831		186,846		186,846	186,846		21	
22	Employee Benefits & Payroll Taxes			281,135	281,135		281,135	(2,517) 278,618		22	
23	Inservice Training & Education			2,156	2,156		2,156	2,156		23	
24	Travel and Seminar			677	677		677	677		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			17,786	17,786		17,786	17,786		26	
27	Other (specify):*									27	
28	TOTAL General Administration	217,674	24,831	339,876	582,381		582,381	(2,523) 579,858		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,975	270,750	482,919	2,167,644		2,167,644	(2,523) 2,165,121		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:

7-1-05

Ending:

6-30-06

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			6,099	6,099	(3,227)	2,872	29,320	32,192			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			914	914		914	65,995	66,909			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			132,969	132,969		132,969	(132,969)				34
35	Rent-Equipment & Vehicles			13,972	13,972		13,972	(4,916)	9,056			35
36	Other (specify):* See Notes			205	205	3,227	3,432		3,432			36
37	TOTAL Ownership			154,159	154,159		154,159	(42,570)	111,589			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			134,705	134,705		134,705		134,705			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			134,705	134,705		134,705		134,705			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,413,975	270,750	771,783	2,456,508		2,456,508	(45,093)	2,411,415			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:

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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	(2,517)	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	(6)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,523)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(42,570)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (42,570)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (45,093)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Park Lawn Center

ID# 0027078

Report Period Beginning: 7-1-05

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Allowable Depreciation from Related Party	\$ 29,320	30	1
2	Allowable Interest from Related Party	65,995	32	2
3	Rent - Facility & Grounds	(132,969)	34	3
4	Rent - Equipment & Vehicles	(4,916)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(42,570)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-05

Ending:

6-30-06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6)	0	0	0	0	0	0	0	0	0	0	(6)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,517)	0	0	0	0	0	0	0	0	0	0	(2,517)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,523)	0	0	0	0	0	0	0	0	0	0	(2,523)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,523)	0	0	0	0	0	0	0	0	0	0	(2,523)	29

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center

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Ending:

Summary B

6-30-06

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	29,320	0	0	0	0	0	0	0	0	0	0	29,320	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	65,995	0	0	0	0	0	0	0	0	0	0	65,995	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(132,969)	0	0	0	0	0	0	0	0	0	0	(132,969)	34
35	Rent-Equipment & Vehicles	(4,916)	0	0	0	0	0	0	0	0	0	0	(4,916)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(42,570)	0	(42,570)	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)	(45,093)	0	(45,093)	45									

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-05

Ending:

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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 Explanation on page 5A	N/A	\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-05 Ending: 6-30-06

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

0027078 Report Period Beginning: 7-1-05 Ending: 6-30-06

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 Administration				\$	\$		\$	1
2	and Accounting and Bookkeeping. This is 6.96% of Total Square Footage 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

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	1-1-03	\$ 20,662	\$ 6,803	1-1-08	5.5000	\$ 182	1									
2	Founders Bank		Mortgage	interest	12-29-05	3,000,000	3,000,000	12-15-12	4.8750	65,813	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Fifth Third Bank		Funding of Program Deficits	\$7,404.00	3-1-03	254,384		5-1-06	5.5000	349	6									
7	LaSalle Bank		Funding of Program Deficits	interest	11-30-05	285,000		open	6.7500	565	7									
8											8									
9	TOTAL Facility Related			\$7,798.71		\$ 3,560,046	\$ 3,006,803			\$ 66,909	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 3,560,046	\$ 3,006,803			\$ 66,909	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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 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 2005 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 200!

(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. _____	_____	\$ _____	\$ _____
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 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2006

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

Facility Name & ID Number Park Lawn Center

0027078 Report Period Beginning:

7-1-05 Ending:

6-30-06

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:

A. Land.

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

Facility Name & ID Number Park Lawn Center

0027078

Report Period Beginning:

7-1-05

Ending:

6-30-06

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	41		1982		\$ 210,000	\$ 6,000	35	\$ 6,000	\$	\$ 142,636	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Plumbing, Heat & AC		1982	165,500	4,729	35	4,729		113,496	9
10		Electric & Fixtures		1982	81,400	2,326	35	2,326		55,824	10
11		Elevator		1982	33,385	954	35	954		22,896	11
12		Concrete		1982	43,171	1,233	35	1,233		14,796	12
13		Sprinklers		1982	22,085	631	35	631		15,144	13
14		Bath. Access.		1982	2,450	70	35	70		1,680	14
15		Construction Int		1982	18,357	525	35	525		12,600	15
16		Carpentry		1982	23,800	680	35	680		16,320	16
17		Windows		1982	33,088	945	35	945		22,680	17
18		Ceramic Tile		1982	10,621	303	35	303		7,272	18
19		Painting		1982	10,166	290	35	290		6,960	19
20		Various Construction Materials		1982	75,966	2,170	35	2,170		52,080	20
21		Permits		1982	1,803	52	35	52		1,248	21
22		Architech Fee		1982	29,577	844	35	844		20,256	22
23		Construction Manager		1982	40,000	1,143	35	1,143		27,432	23
24		Demolition		1982	6,858	196	35	196		4,704	24
25		Windows		1983	4,258	171	25	171		3,922	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		688	29
30		Generator		1986	15,785	388	20	388		15,785	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		17,441	34
35		Tile, Main Area, Floor Patch		2001	5,857	586	10	586		2,782	35
36		Compressor		2004	2,475	165	15	165		330	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:

7-1-05

Ending:

6-30-06

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	\$ 85	15	\$ 85	\$	\$ 164	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	\$ 26,279		\$ 26,279	\$	\$ 605,822	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: 7-1-05 Ending: 6-30-06

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	\$ 28,690	\$ 3,142	\$ 3,142	\$	various	\$ 19,905	71
72	Current Year Purchases	2,095	349	349		5	349	72
73	Fully Depreciated Assets	144,150	292	292			144,150	73
74								74
75	TOTALS	\$ 174,935	\$ 3,783	\$ 3,783	\$		\$ 164,404	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 25. Small % of many vehicles			\$	\$	\$	\$		\$	76
77	are used for program.			35,143	2,130	2,130		5	28,516	77
78										78
79										79
80	TOTALS			\$ 35,143	\$ 2,130	\$ 2,130	\$		\$ 28,516	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)	\$ 1,291,883	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,192	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,192	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)	\$ 798,742	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	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: \$ 9,056 Description: Pagers \$187, Copiers \$7,252, PACE \$1,617

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See attached listing page 26.</u>		\$ <u>84.00</u>	\$ <u>1,005</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>84.00</u>	\$ <u>1,005</u>	21

10. Effective dates of current rental agreement:

Beginning 7-1-05

Ending 6-30-06

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

Fiscal Year Ending Annual Rent

12. 6/30/2007 \$ 129,749

13. 6/30/2008 \$ 129,749

14. 6/30/2009 \$ 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: 7-1-05 Ending: 6-30-06

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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: 7-1-05

Ending:

6-30-06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6-30-06

(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	\$ 456,245	\$	1
2	Cash-Patient Deposits	49,036		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	14,025		5
6	Prepaid Insurance	72,947		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	784,157		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,376,410	\$	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	427,382		16
17	Accumulated Depreciation (book methods)	(356,491)		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)	\$ 70,891	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,447,301	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 98,614	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,036		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	332,152		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,593		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>	7,326		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 488,721	\$	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 & Leases</u>	853,638		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 853,638	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,342,359	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 104,942	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,447,301	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 91,018	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 91,018	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Income from other department	13,924	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 13,924	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)	\$ 104,942	24 *

* This must agree with page 17, line 47.

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

0027078

Report Period Beginning: **7-1-05**

Ending:

6-30-06

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	\$ 2,278,666	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,278,666	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	10,221	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)	\$ 10,221	23
D. Non-Operating Revenue			
24	Contributions	167,621	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 167,621	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,456,508	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	480,109	31
32	Health Care	1,105,154	32
33	General Administration	582,381	33
B. Capital Expense			
34	Ownership	154,159	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	134,705	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,456,508	40
41	Income before Income Taxes (line 30 minus line 40)**		41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	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:

7-1-05

Ending:

6-30-06

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	1,002	1,209	\$ 32,967	\$ 27.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,950	4,441	98,630	22.21	3
4	Licensed Practical Nurses	3,068	3,213	69,078	21.50	4
5	CNAs & Orderlies	1,080	1,169	11,071	9.47	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	205	210	5,468	26.04	11
12	Dietician					12
13	Food Service Supervisor	1,401	1,653	24,946	15.09	13
14	Head Cook	838	1,077	13,043	12.11	14
15	Cook Helpers/Assistants	9,084	9,663	78,251	8.10	15
16	Dishwashers					16
17	Maintenance Workers	3,214	3,691	48,373	13.11	17
18	Housekeepers	4,004	4,404	45,699	10.38	18
19	Laundry	1,825	2,013	15,129	7.52	19
20	Administrator	1,059	1,253	55,659	44.42	20
21	Assistant Administrator					21
22	Other Administrative	5,251	6,115	122,827	20.09	22
23	Office Manager	1,628	2,056	39,188	19.06	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,080	5,732	82,221	14.34	28
29	Resident Services Coordinator	622	720	22,334	31.02	29
30	Habilitation Aides (DD Homes)	54,602	59,851	590,633	9.87	30
31	Medical Records					31
32	Other Health Ca <u>Psycholoist</u>	73	73	5,875	80.48	32
33	Other(specify) <u>See Notes</u>	4,280	4,801	52,583	10.95	33
34	TOTAL (lines 1 - 33)	102,266	113,344	\$ 1,413,975 *	\$ 12.48	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	252	\$ 5,040	1-3	35
36	Medical Director	49	6,075	9-3	36
37	Medical Records Consultant	15	525	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	441	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	109	5,968	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatrist</u>	34	6,000	15-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	\$ 24,049		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	350	\$ 21,255	10-3	50
51	Licensed Practical Nurses	844	30,609	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,194	\$ 51,864		53

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 Director	0	\$ 37,232	Workers' Compensation Insurance	\$ 36,802	IDPH License Fee	\$ 15,243	
Julie Grounds	Deputy Executive Dir.	0	18,427	Unemployment Compensation Insurance	16,781	Advertising: Employee Recruitment	571	
				FICA Taxes	104,443	Health Care Worker Background Check (Indicate # of checks performed <u>57</u>)		
				Employee Health Insurance	117,162	Patient Background Checks		
				Employee Meals		Membership Dues	2,882	
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions & Texts	6	
				Employer Match TSA	3,430	Public Relations	6	
				Man Ben \$2517 not included in total		License Fee Other	226	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,659			Less: Public Relations Expense	(6)	
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)	\$ 278,618	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,928	
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
James Himmel	Legal		\$ 278				Out-of-State Travel	\$
Vanden Berk LLC	Legal		536					
Cocalas, Westberg & Mommsen	Audit		3,891				In-State Travel	
ADP	Payroll		8,863					
Intergration Works	Data Processing		5,620				Seminar Expense	
							Arc of Illinois	677
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,188	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 677

* 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. \$ 16,691 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. \$ 134,705
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.

Related Party Adjustment

Park Lawn Center

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2005/2006 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMEN	ORS	CILA	126TH ST. RESIDENTIAL	115TH ST. RESIDENTIAL
Total Lease	380,769	61,702	106,488	12,440	3,142	17,748	32,308	146,941
LESS: Community Lease	38,252	7,201	14,251	2,758	146	3,482	1,358	9,056
Related Organization	342,517	54,501	92,237	9,682	2,996	14,266	30,950	137,885
Interest & Depreciation Related Organization	361,840	20,348	73,007	7,016	2,378	87,221	89,376	82,494
Adjustment	19,323	(34,153)	(19,230)	(2,666)	(618)	72,955	58,426	(55,391)
Adjust Related Organization	361,840	20,348	73,007	7,016	2,378	87,221	89,376	82,494
Community Lease	38,252	7,201	14,251	2,758	146	3,482	1,358	9,056
Grand Total Allowable Lease	400,092	27,549	87,258	9,774	2,524	90,703	90,734	91,550
Other Adjustments								
Management Benefits	(6,856)	(570)	(1,158)	(245)	(77)	(1,592)	(697)	(2,517)
Public Relations	(6,503)	(1)	(6,490)	0	0	(4)	(2)	(6)
In Kind	0	0	0	0	0	0	0	0
Total Interest	PLA 147,714.00	PLH 55,154.00						
Total Depreciation	142,886.00	33,682.00						
	290,600.00	88,836.00		PLA Depreciation			Mortgage Interest	147,000.00
PLH	88,836.00			Bldg. Depreciation	110,034.00		Vehicle Interest	714
	379,436.00			Equipment Depreciation	32,852.00			147,714.00
Fundraising	-17,595.97				142,886.00			

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	\$0.00	0	\$0.00	\$0.00	\$0.00	-	5	\$19,094.00
88 Medical Appts.	00 Dodge Maxi Van	*	2000	\$19,977.00	\$166.47	8	\$13.32	\$3,995.40	\$13.32	-	5	\$19,810.53
89 Medical Appts.	01 Light Duty Ford Eld*		2002	\$44,353.00	\$8,870.60	8	\$709.65	\$8,870.60	\$709.65	-	5	\$23,654.93
90 Medical Appts.	02 Mini Van Chevy Ve*		2002	\$33,545.00	\$6,709.00	8	\$536.72	\$6,709.00	\$536.72		5	\$17,890.67
91 Medical Appts.	03 Ford Eldorado	*	2003	\$54,404.53	\$10,880.91	8	\$870.47	\$10,881.00	\$870.47		5	\$15,414.62
				\$394,786.53	\$26,626.98		\$2,130.16	\$30,456.00	\$2,130.16			\$319,277.75

* Owned by Park Lawn School Depreciation \$2,130.16

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

\$2,130.16

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	0.4	\$66	\$796.80
18 Activities		97 Ford Club Wagon	\$228.00	0.076	\$17	\$207.94
<hr/>						
21 Totals			\$394.00		\$84	\$1,004.74

Equipment	Year of Acquisition	Cost	Public-Use Life in Years	Public-Use Straight-Line Depreciation
Various Equipment	1983-1987	\$54,018.23	15	\$0.00 Fully Depreciated
Various Equipment	1983-1987	\$46,932.33	20	\$0.00 Fully Depreciated
		\$63,930.57		
EQUIPMENT 9882				
Building	1987	\$20,000.00	3	\$0.00 Fully Depreciated
Flap Shampooer	1987	\$1,300.00	3	\$0.00 Fully Depreciated
		\$1,300.00		
EQUIPMENT 9883				
Tire Floor	1989	\$1,483.00	20	\$0.00 Fully Depreciated
Carpeting	1989	\$1,439.00	7	\$0.00 Fully Depreciated
		\$2,922.00		
EQUIPMENT 9890				
Time Clock	1990	\$1,100.00	7	\$0.00 Fully Depreciated
Card Rack	1990	\$75.00	10	\$0.00 Fully Depreciated
Carpeting	1990	\$4,833.00	5	\$0.00 Fully Depreciated
		\$6,008.00		
EQUIPMENT 9891				
Insulated Heated Cabinet	1991	\$1,382.00	10	\$0.00 Fully Depreciated
		\$1,382.00		
EQUIPMENT 9182				
Mattresses	1991	\$1,188.00	5	\$0.00 Fully Depreciated
Daisies (2)	1991	\$207.00	5	\$0.00 Fully Depreciated
Daisies (2)	1991	\$144.00	5	\$0.00 Fully Depreciated
13 Inch TV	1991	\$80.00	5	\$0.00 Fully Depreciated
Potential Scales	1992	\$205.00	5	\$0.00 Fully Depreciated
Urns - Stainless Hinges	1992	\$135.00	5	\$0.00 Fully Depreciated
Band Lines (2)	1992	\$110.00	5	\$0.00 Fully Depreciated
Table Lamps	1992	\$97.00	5	\$0.00 Fully Depreciated
Recliner/Chair/Chair	1992	\$170.00	5	\$0.00 Fully Depreciated
Table (1000)	1992	\$100.00	5	\$0.00 Fully Depreciated
Table (1000)	1992	\$100.00	5	\$0.00 Fully Depreciated
Table (1000)	1992	\$100.00	5	\$0.00 Fully Depreciated
Walker - Aluminum	1992	\$75.00	5	\$0.00 Fully Depreciated
		\$4,722.00		
EQUIPMENT 9293				
Toaster	1993	\$200.00	5	\$0.00 Fully Depreciated
19" TV	1993	\$200.00	5	\$0.00 Fully Depreciated
File Cabinets	1993	\$234.00	5	\$0.00 Fully Depreciated
Chairs	1993	\$170.00	5	\$0.00 Fully Depreciated
Vacuums	1993	\$253.00	5	\$0.00 Fully Depreciated
Washers - Tool	1993	\$170.00	5	\$0.00 Fully Depreciated
Waffle Cook	1993	\$227.00	5	\$0.00 Fully Depreciated
Air Compressor	1993	\$270.00	5	\$0.00 Fully Depreciated
Food Processor	1993	\$190.00	5	\$0.00 Fully Depreciated
Lockers	1993	\$146.00	5	\$0.00 Fully Depreciated
Mattresses (2)	1993	\$402.00	5	\$0.00 Fully Depreciated
Vertical Blinds	1993	\$276.00	5	\$0.00 Fully Depreciated
Intercom	1993	\$50.00	5	\$0.00 Fully Depreciated
		\$3,542.00		
EQUIPMENT 9394				
Vertical Blinds	1994	\$343.00	7	\$0.00 Fully Depreciated
Washing Machine	1994	\$343.00	5	\$0.00 Fully Depreciated
Chair/Futon	1994	\$638.00	5	\$0.00 Fully Depreciated
Floor Light	1994	\$204.00	5	\$0.00 Fully Depreciated
Garbage Can/Step On	1994	\$444.00	5	\$0.00 Fully Depreciated
Lantern Case	1994	\$137.00	5	\$0.00 Fully Depreciated
Fan/Blower	1994	\$276.00	5	\$0.00 Fully Depreciated
Power	1994	\$238.00	5	\$0.00 Fully Depreciated
		\$4,334.00		
EQUIPMENT 9495				
Sofa, Love Seat, Chairs Tables	1995	\$3,300.00	10	\$0.00 Fully Depreciated
Luxury Bath Seat	1995	\$134.00	5	\$0.00 Fully Depreciated
Box Springs (2)	1995	\$2,280.00	5	\$0.00 Fully Depreciated
TV Cabinets (2)	1995	\$208.00	5	\$0.00 Fully Depreciated
Magnets, C/P	1995	\$200.00	5	\$0.00 Fully Depreciated
Refrigerator	1995	\$1,200.00	5	\$0.00 Fully Depreciated
Microwave (Custar)	1995	\$179.00	5	\$0.00 Fully Depreciated
Tables (Round Control)	1995	\$81.00	5	\$0.00 Fully Depreciated
Chairs (3)	1995	\$302.00	5	\$0.00 Fully Depreciated
		\$4,977.00		
EQUIPMENT 9596				
Chairs (10)	1996	\$237.00	10	\$2.81 Fully Depreciated
Chair	1996	\$119.00	10	\$2.82 Fully Depreciated
Club Chairs	1996	\$2,164.00	10	\$216.56 Fully Depreciated
Lamps	1996	\$244.00	10	\$24.40 Fully Depreciated
Felties	1996	\$38.00	10	\$3.80 Fully Depreciated
Sink Dispensers	1996	\$325.00	10	\$32.50 Fully Depreciated
Ice Cream Maker	1996	\$219.00	7	\$21.90 Fully Depreciated
Dryer - Gas	1996	\$234.00	7	\$23.40 Fully Depreciated
Washer/Dryer	1996	\$1,100.00	7	\$110.00 Fully Depreciated
		\$18,330.00		\$282.49
EQUIPMENT 9697				
Del Computer	1997	\$2,200.00	10	\$220.00
Multimedia Scanner	1997	\$1,370.00	10	\$137.00
Two Servers	1997	\$1,400.00	10	\$140.00
		\$5,100.00		\$297.00
EQUIPMENT 9798				
Stoves	1998	\$675.00	7	\$0.00 Fully Depreciated
2 Del Computers	1998	\$9,465.00	10	\$946.50
		\$10,120.00		\$946.50
EQUIPMENT 9899				
2 Chairs	1999	\$260.00	10	\$260.00
EQUIPMENT 9900				
NO NEW EQUIPMENT				
EQUIPMENT 0001				
Hot Water Heater	2001	\$4,280.00	20	\$214.00
EQUIPMENT 0102				
NO NEW EQUIPMENT				
EQUIPMENT 0203				
Access Egress Table	2002	\$1,364.61	7	\$194.00
EQUIPMENT 0304				
Seat & Back Cushions	2003	\$1,819.75	7	\$259.96
EQUIPMENT 0405				
NO NEW EQUIPMENT				
EQUIPMENT 0506				
4 Computers DX 2000	1994	\$2,084.05	5	\$416.11
Total P/LA Equipment/Depreciation		\$161,346.73		\$3,041.56
Park Lawn School & Athletic Center				
EQUIPMENT 9697				
Phone System	1996	\$9,137.00	5	\$0.00 Fully Depreciated
Wet Dry Vacuum	1996	\$238.00	5	\$0.00 Fully Depreciated
		\$9,375.00		
EQUIPMENT 0102				
Accounting Software (Program %)	2001	\$2,977.11	5	\$595.42
EQUIPMENT 0203				
Accounting Software (Program %)	2003	\$302.23	5	\$70.86
EQUIPMENT 0405				
Human Resource Desk Furniture (Program %)	2004	\$933.30	7	\$75.46
Total P/LA Equipment/Depreciation		\$13,587.64		\$741.74
Total Equipment Both Corporations		\$174,934.37		\$3,783.30
Total Depreciation Both Corporations				\$3,783.30

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	\$33,282
Plant Security	\$68
	<u>\$33,370</u>

Line 15 Column 1

QMRP	\$82,221
Res. Serv. Coord.	\$22,334
Hab. Aides	\$590,633
Facility/Service Aide	\$28,786
Staff Traainer	\$4,103
Psychiatrist	\$5,875
	<u>\$733,952</u>

Line 15 Column 3

Psychiatrist Consultant	\$6,000
Other Consultants	\$725
	<u>\$6,725</u>

Line 23 Column 8

American Red Cross	CPR Class materials	\$255.22
Armstrong Medical	CPR Class materials	\$106.43
Bethesda Luther. Home	Abuse & Neglect Material	\$115.80
ILL. Health Care Assn.	Therapeutic Activities Seminar	\$544.61
Safe Food Handler Corp.	Safe Food Handling	\$60.00
Young Adult Inst.	Training Tapes	\$75.61
NFP Consultants	Computer Training	\$225.37
The Arc of Illinois	Leadership Conference	\$320.00
Safeway	Refreshments	\$452.96
		<u>\$2,156.00</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 36 Column 3 \$205 Loss on disposition of assets.

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

Building Depreciation	\$25,863.00
Equipment Depreciation	\$3,040.00
	<u>\$28,903.00</u>

Line 35 Column 8 Community Leased equipment: Pagers \$187, Copier \$7,252, PACE \$1,617

Schedule VII, Part B

Park Lawn Association, Inc.		
Building Rental not allowed		(\$132,969)
Equipment Rental not allowed		(\$4,916)
Allowable Building Interest	\$65,813	
Allowable Vehicle Interest \$501 X 36.33%	<u>\$182</u>	
		\$65,995

Depreciation Allowed		
Building	26,279	
Equipment	<u>3,041</u>	
Total Depreciation Allowed *		<u>\$29,320</u>

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

Total Related Party Adjustment Detailed on Page 5A line 49 (\$42,570.00)

Schedule IX Interest Expense Column 10

Hinsdale Bank	This programs share of vehicle interest \$501 X 36.33%	\$182.00
Founders Bank	This programs mortgage interest allowed from related party	\$65,813.00
Fifth Third Bank	This programs share of deficit funding interest \$1229X 28.39	\$349.00
LaSalle Bank	This programs share of deficit funding interest 3000 X 18.83	\$565.00

Schedule XI. Part D

Line 46 Column 5 Includes only the program portion of depreciation costs on vehicles. Due to the number of participants 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 26.

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	\$19,694
Facilities Service Aide	\$28,786
Trainer	\$4,103
	<u>\$52,583</u>

Schedule XX. Page 23

Question 12 Allocated on basis of hours worked per department

Question 15 No Employee meals are served