FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0027078

Facility Name: Park Lawn Center

Address: 5831 West 115th St (Number) Alsip (City) 60803 (Zip Code)

County: Cook

Telephone Number: 708-396-1117 **Fax #** 708-396-1186

HFS ID Number:

Date of Initial License for Current Owners: 9-22-82

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Thomas Ryan **Telephone Number:** 708-634-0513
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2024 to 6/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 10/28/2025 (Date)
(Type or Print Name) Thomas Ryan
(Title) Finance Director

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD			13,682					13,682	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS			13,682					13,682	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 91.43%

D. How many bed reserve days during this year were paid by the Department?
52 (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/22/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/22/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	332,857	10,736	6,367	349,960		349,960		349,960			1
2	Food Purchase		160,125		160,125		160,125		160,125			2
3	Housekeeping	76,106	8,729		84,835		84,835		84,835			3
4	Laundry	69,434	9,317		78,751		78,751		78,751			4
5	Heat and Other Utilities			90,292	90,292		90,292		90,292			5
6	Maintenance	64,310	22,962	56,526	143,798		143,798		143,798			6
7	Other (specify):*		4,866		4,866		4,866		4,866			7
8	TOTAL General Services	542,707	216,735	153,185	912,627		912,627		912,627			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	502,927	104,337	66,274	673,538		673,538		673,538			10
10a	Therapy			10,822	10,822		10,822		10,822			10a
11	Activities	45,248	6,032		51,280		51,280		51,280			11
12	Social Services	8,921			8,921		8,921		8,921			12
13	CNA Training											13
14	Program Transportation		11,833	3,857	15,690		15,690		15,690			14
15	Other (specify):*	1,395,713		35,192	1,430,905		1,430,905		1,430,905			15
16	TOTAL Health Care and Programs	1,952,809	122,202	116,145	2,191,156		2,191,156		2,191,156			16
	C. General Administration											
17	Administrative	516,878			516,878		516,878		516,878			17
18	Directors Fees											18
19	Professional Services			58,307	58,307		58,307		58,307			19
20	Dues, Fees, Subscriptions & Promotions			15,017	15,017		15,017	(8,645)	6,372			20
21	Clerical & General Office Expenses		27,602		27,602		27,602		27,602			21
22	Employee Benefits & Payroll Taxes			561,177	561,177		561,177		561,177			22
23	Inservice Training & Education			9,184	9,184		9,184		9,184			23
24	Travel and Seminar			334	334		334		334			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			29,243	29,243		29,243		29,243			26
27	Other (specify):*											27
28	TOTAL General Administration	516,878	27,602	673,262	1,217,742		1,217,742	(8,645)	1,209,097			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,012,394	366,539	942,592	4,321,525		4,321,525	(8,645)	4,312,880			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: 7/1/2024 Ending: 6/30/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,118	2,118		2,118	123,647	125,765			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							10,025	10,025			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			136,416	136,416		136,416	(136,416)				34
35	Rent-Equipment & Vehicles			13,558	13,558		13,558		13,558			35
36	Other (specify):*											36
37	**TOTAL Ownership**			152,092	152,092		152,092	(2,744)	149,348			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			219,332	219,332		219,332		219,332			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			219,332	219,332		219,332		219,332			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,012,394	366,539	1,314,016	4,692,949		4,692,949	(11,389)	4,681,560			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: 7/1/2024 Ending: 6/30/2025

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(8,512)	5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,512)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,512)		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 Yes	2 No	3 Amount	4 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						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: 7/1/2024

Ending: 6/30/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (8,645)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13	Allowable Depreciation from Related Party	123,647	30	13
14	Allowable Interest from Related Party	10,025	32	14
15	Rent Facility & Grounds	(136,416)	34	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**	(11,389)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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	(8,645)	0	0	0	0	0	0	0	0	0	0	(8,645)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,645)	0	0	0	0	0	0	0	0	0	0	(8,645)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,645)	0	0	0	0	0	0	0	0	0	0	(8,645)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Lawn Center **#** 0027078 **Report Period Beginning:** 7/1/2024 **Ending:** 6/30/2025

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

	Capital Expense D. Ownership	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)	
30	Depreciation	123,647	0	0	0	0	0	0	0	0	0	0	123,647	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	10,025	0	0	0	0	0	0	0	0	0	0	10,025	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(136,416)	0	0	0	0	0	0	0	0	0	0	(136,416)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,744)	0	0	0	0	0	0	0	0	0	0	(2,744)	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)**	(11,389)	0	0	0	0	0	0	0	0	0	0	(11,389)	45

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Park Lawn Assn.	Oak Lawn	Support Org.

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Park Lawn Center

ID# **0027078**

Report Period Beginning: **7/1/2024**

Ending: **6/30/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Maureen		Reilly	Palos Park	IL	0.00000	0.00000	0.00000	1
2	Cheri		Boublis	Palos Heights	IL	0.00000	0.00000	0.00000	2
3	Courtney		Joyce	Orland Hills	IL	0.00000	0.00000	0.00000	3
4	Vicki		Scanlon	Chicago	IL	0.00000	0.00000	0.00000	4
5	Robert		Barnes	Orland Park	IL	0.00000	0.00000	0.00000	5
6	James		Himmel	Flossmoor	IL	0.00000	0.00000	0.00000	6
7	Dianna		Parkman	Blue Island	IL	0.00000	0.00000	0.00000	7
8	Patricia		Singler	Chicago	IL	0.00000	0.00000	0.00000	8
9	Phil		Kujawa	Chicago	IL	0.00000	0.00000	0.00000	9
10									10
11									11
12									12
13	Non-Profit Board					100.00000	100.00000	100.00000	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
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75									75

STATE OF ILLINOIS **Ownership Listing-2**

Park Lawn Center

ID# **0027078**

Report Period Beginning: **7/1/2024**

Ending: **6/30/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
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147									147
148									148
149									149
150									150

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
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								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 7/1/2024 Ending: 6/30/2025

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		See Page 23				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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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: 7/1/2024 Ending: 6/30/2025

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIBC		X	Mortgage	$2,106.91	12/15/2012	$ 3,000,000	$ 183,120	12/01/2035	4.7500	$ 10,025	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,106.91		$ 3,000,000	$ 183,120			$ 10,025	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,000,000	$ 183,120			$ 10,025	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.)

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027078

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,891 B. General Construction Type: Exterior Brick Aluminum Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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).

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES ____ NO ____ If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facilities	124,955	1981	$ 190,000	1
2					2
3	TOTALS	124,955		$ 190,000	3

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	41			1982	$ 210,000	$		$	$	$ 210,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing, Heat & AC			1982	165,500		35			165,500	9
10	Electric & Fixtures			1982	81,400		35			81,400	10
11	Elevator			1982	33,385		35			33,385	11
12	Concrete			1982	43,171		35			43,171	12
13	Sprinklers			1982	22,085		35			22,085	13
14	Bath. Access.			1982	2,450		35			2,450	14
15	Construction Int			1982	18,357		35			18,357	15
16	Carpentry			1982	23,800		35			23,800	16
17	Windows			1982	33,088		35			33,088	17
18	Ceramic Tile			1982	10,621		35			10,621	18
19	Painting			1982	10,166		35			10,166	19
20	Various Construction Materials			1982	75,966		35			75,966	20
21	Permits			1982	1,803		35			1,803	21
22	Architect Fee			1982	29,577		35			29,577	22
23	Construction Manager			1982	40,000		35			40,000	23
24	Demolition			1982	6,858		35			6,858	24
25	Windows			1983	4,258		25			4,258	25
26	Sewer & Sump Pump			1983	4,933		10			4,933	26
27	Windows			1986	850		25			850	27
28	Generator			1986	15,785		20			15,785	28
29	Fence/Gate			1993	2,053		10			2,053	29
30	Roof Repair			1997	26,382		15			26,382	30
31	Tile Main area and Floor Patch			2001	5,857		10			5,857	31
32	Compressor			2004	2,475		15			2,475	32
33	4 Stage Chiller			2005	1,285		15			1,285	33
34	Elevator Pump			2005	6,200		10			6,200	34
35	General Contractor Job Superintendent			2007	180,564	4,514	40	4,514		82,381	35
36	General Contractor Fees			2007	210,949	5,274	40	5,274		96,250	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ins & Permits	2007	$ 184,211	$ 4,605	40	$ 4,605	$	$ 84,042	37
38	Estimate Contingency	2007	1,471	37	40	37		675	38
39	Roofing	2007	185,247	4,631	40	4,631		84,516	39
40	Metal Wall Panels	2007	17,760	444	40	444		8,103	40
41	Sun Screens	2007	46,408	1,160	40	1,160		21,170	41
42	HVAC	2007	230,756	5,769	40	5,769		105,284	42
43	Electrial	2007	366,412	9,160	40	9,160		167,170	43
44	Final Cleaning	2007	1,145	29	40	29		529	44
45	Selective Demolition	2007	39,425	986	40	986		17,994	45
46	Earthwork	2007	103,726	2,593	40	2,593		47,322	46
47	Asphalt Paving	2007	56,525	1,413	40	1,413		25,794	47
48	Fencing	2007	12,113	303	40	303		5,530	48
49	Landscapomg	2007	23,679	592	40	592		10,804	49
50	Concrete	2007	148,644	3,716	40	3,716		67,817	50
51	Steel	2007	18,829	471	40	471		8,595	51
52	Carpentry	2007	592,248	14,806	40	14,806		271,269	52
53	Millwork	2007	35,126	878	40	878		16,024	53
54	Drywall & acoustical	2007	233,229	5,831	40	5,831		106,415	54
55	Calking	2007	4,232	106	40	106		1,934	55
56	Door & Hardware	2007	77,373	1,934	40	1,934		35,296	56
57	R/R Coiling Doors	2007	3,148	79	40	79		1,441	57
58	Overhead Doors	2007	3,450	86	40	86		1,570	58
59	Aluminum Entrances	2007	67,203	1,680	40	1,680		30,660	59
60	Wood Windows	2007	82,549	2,064	40	2,064		37,669	60
61	Tile & Carpet	2007	126,869	3,172	40	3,172		57,889	61
62	Painting	2007	47,690	1,192	40	1,192		21,754	62
63	Toilet Acc/Floor Mat/ Fire Ext/ Tack board	2007	15,955	399	40	399		7,182	63
64	Aceovyn Wall Protection	2007	20,486	512	40	512		9,344	64
65	Fire Protection	2007	112,086	2,802	40	2,802		51,137	65
66	Plumbing	2007	387,850	9,696	40	9,696		176,952	66
67	Low Voltage	2007	20,482	512	40	512		9,344	67
68	Fire Hydrant	2007	9,975	249	40	249		4,545	68
69	Two Monument Signs	2007	4,750	119	40	119		2,171	69
70	TOTAL (lines 4 thru 69)		$ 4,550,870	$ 91,814		$ 91,814	$	$ 2,554,877	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: 7/1/2024 Ending: 6/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,550,870	$ 91,814		$ 91,814	$	$ 2,554,877	1
2	Metal Studs	2007	13,225	331	40	331		6,040	2
3	Architect	2007	348,281	8,707	40	8,707		158,903	3
4	Legal	2007	4,095	102	40	102		1,862	4
5	Soil Boring	2007	1,200	30	40	30		548	5
6	Survey	2007	2,300	58	40	58		1,058	6
7	Phone System	2007	12,262	307	40	307		5,602	7
8	Title Company Fees	2007	5,410	135	40	135		2,464	8
9	General Contractor Job Superintendent	2007	22,050	551	40	551		9,643	9
10	General Contractor Fees	2007	71,712	1,793	40	1,793		31,377	10
11	Roofing	2008	53,578	1,339	40	1,339		23,333	11
12	Sun Screens	2008	27,467	687	40	687		12,022	12
13	HVAC	2008	42,548	1,064	40	1,064		18,594	13
14	Electricial	2008	42,114	1,053	40	1,053		18,427	14
15	Selective Demolition	2008	2,018	50	40	50		875	15
16	Earthwork	2008	5,459	136	40	136		2,380	16
17	Asphalt Paving	2008	2,975	74	40	74		1,295	17
18	Fencing	2008	638	16	40	16		280	18
19	Landscaping	2008	8,958	224	40	224		3,963	19
20	Concrete	2008	7,823	196	40	196		3,430	20
21	Steel	2008	3,641	91	40	91		1,593	21
22	Carpntry	2008	31,944	799	40	799		13,982	22
23	Millwork	2008	11,554	289	40	289		5,057	23
24	Drywall & Acoustical	2008	54,781	1,370	40	1,370		23,975	24
25	Doors & Hardware	2008	5,007	125	40	125		2,187	25
26	Aluminum Entrances	2008	8,517	213	40	213		3,727	26
27	Wood Windows	2008	1,395	35	40	35		612	27
28	Tile & Carpet	2008	12,794	320	40	320		5,600	28
29	Painting	2008	23,111	578	40	578		10,289	29
30	Toilet Acc/Floor/Mat/Fire Ext/ Tack Board	2008	2,465	62	40	62		1,091	30
31	Acrovyn Wall Protection	2008	472	12	40	12		210	31
32	Fire Protection	2008	37,852	946	40	946		16,555	32
33	Plumbing	2008	41,841	1,043	40	1,043		18,315	33
34	TOTAL (lines 1 thru 33)		$ 5,460,357	$ 114,550		$ 114,550	$	$ 2,960,166	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,460,357	$ 114,550		$ 114,550	$	$ 2,960,166	1
2	Low Voltage	2008	23,516	588	40	588		9,408	2
3	Fire Hydrant	2008	525	13	40	13		208	3
4	Two Monument Signs	2008	12,250	306	40	306		4,896	4
5	Metal Studs	2008	4,295	107	40	107		1,712	5
6	Architect	2008	1,969	49	40	49		784	6
7	Phone System	2008	10,053	251	40	251		4,016	7
8	Aquarium	2009	7,827		10			7,827	8
9	Artwork	2009	1,510		10			1,510	9
10	Dedication Sign	2009	2,553	54	40	54		864	10
11	Two Electric Heaters	2009	1,121	28	40	28		448	11
12	Vinyl Tile Front Entrance	2009	1,468	37	40	37		592	12
13	Wallcovering & Chair Rail	2009	3,992	100	40	100		1,600	13
14	Masonary Restoration	2009	3,685	184	20	184		2,944	14
15	Tuckpointing Bldg.	2010	9,800	490	20	490		7,677	15
16	Parking Lot Lighting	2010	3,480	174	20	174		2,683	16
17	Pump Work	2010	1,522	101	15	101		1,560	17
18	Two Marley Heaters	2010	2,618		10			2,618	18
19	Door Hardware	2010	1,488	74	20	74		1,112	19
20	Crack filling/sealcoating of lot	2010	4,747		10			4,747	20
21	Exhaust Fan add on Elevator Room	2011	2,775		10			2,775	21
22	Canopy Sprinkler Installation	2011	9,290	619	15	619		8,719	22
23	Completion of River Rock to CR Drive	2011	1,097		10			1,097	23
24	Redo Center Landscapting	2011	5,869	391	15	391		5,214	24
25	Water Heater	2012	3,082		10			3,082	25
26	Sprinkler Pipe Chases	2013	4,172	209	20	209		2,559	26
27	Modifications to Fire Sprinkler Piping	2013	12,150	608	20	608		7,446	27
28	Swing Door	2014	1,920	96	20	96		1,024	28
29	Sealcoating, replace 4 wheel stops	2014	4,685		5			4,685	29
30	Trane RTU Economizer	2016	4,429	443	10	443		4,061	30
31	Activity Room Ductless AC split system	2016	8,843	884	10	884		8,030	31
32	PLC Stairwell Doors	2016	10,422	521	20	521		4,255	32
33	Emergency Panel Circuits	2018	2,912	113	15	113		791	33
34	TOTAL (lines 1 thru 33)		$ 5,630,422	$ 120,990		$ 120,990	$	$ 3,071,110	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,630,422	$ 120,990		$ 120,990	$	$ 3,071,110	1
2	Front Entrance Carpet Squares	2019	550	78	7	78		468	2
3	Rooftop Unit RTU Model GBC	2023	34,261	2,310	15	2,310		5,001	3
4	Rooftop Airconditioner	2024	6,399	427	10	427		854	4
5	PLC Phones	2025	5,885	1,177	5	1,177		1,177	5
6	PLC Guest Chairs	2025	11,750	783	5	783		783	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	TOTAL (lines 1 thru 33)		$ 5,689,267	$ 125,765		$ 125,765	$	$ 3,079,393	34

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 5,879,267	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 125,765	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 125,765	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)	$ 3,079,393	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ 13,558 Description: Copier $8,396 Pace $3,000 Misc $2,162
(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	Medical Appointments	2018 Heavy Duty Van	$ 250.00	$ 3,000	17
18					18
19					19
20					20
21	TOTAL		$ 250.00	$ 3,000	21

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

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(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.)

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

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

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,050,530	$	1
2	Cash-Patient Deposits	116,396		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,166,925	$	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	909,027		16
17	Accumulated Depreciation (book methods)	(640,752)		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)**	$ 268,275	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,435,200	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,120,059	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	116,396		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	689,245		30
31	Accrued Taxes Payable (excluding real estate taxes)			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	Reserve for Client Activities	4,271		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,929,971	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	183,120		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 183,120	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,113,091	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,677,891)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,435,200	$	48

*(See instructions.)

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,926,826)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,926,826)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(751,065)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (751,065)	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)**	$ (3,677,891)	24 *

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

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,910,974	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,910,974	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		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	30,909	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,909	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)**	$ 3,941,883	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	395,912	31
32	Health Care	2,960,112	32
33	General Administration	965,500	33
	B. Capital Expense		
34	Ownership	152,092	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	219,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,692,948	40
41	**Income before Income Taxes (line 30 minus line 40)****	(751,065)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (751,065)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	56

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,307	3,578	$ 193,465	$ 54.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,919	6,289	245,391	39.02	3
4	Licensed Practical Nurses	1,706	1,709	64,072	37.49	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,171	2,417	45,248	18.72	10
11	Social Service Workers	248	248	8,921	35.97	11
12	Dietician					12
13	Food Service Supervisor	2,220	2,363	55,563	23.51	13
14	Head Cook	4,549	4,763	100,886	21.18	14
15	Cook Helpers/Assistants	8,327	8,722	176,407	20.23	15
16	Dishwashers					16
17	Maintenance Workers	2,938	3,155	64,310	20.38	17
18	Housekeepers	3,643	3,952	76,105	19.26	18
19	Laundry	3,234	3,387	69,434	20.50	19
20	Administrator	882	882	37,755	42.81	20
21	Assistant Administrator	4,402	4,628	129,239	27.93	21
22	Other Administrative	13,020	13,713	349,884	25.51	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	2,919	3,075	76,505	24.88	28
29	Resident Services Coordinator	4,437	4,721	114,840	24.33	29
30	Habilitation Aides (DD Homes)	52,831	55,104	1,204,369	21.86	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,753	122,706	$ 3,012,394 *	$ 24.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	88	$ 6,367	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	40	2,432	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	228	10,822	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	24	5,000	10-3	46
47	Behavioral	466	35,192	15-3	47
48					48
49	TOTAL (lines 35 - 48)	846	$ 59,813		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	779	$ 58,842	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	779	$ 58,842		53

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonnie Willet	Dir of Res Svcs		$ 37,755
Amy Pitt	Asst. Admin		46,946
Kerrie Kupfer	Program Manager		73,720
Sali Moflehi	QDIP Manager		64,635
Frank Portada	Exectuive Director		55,386
Denise Rau	Ass. Exectuive Director		42,246
HR & Finance See page 23	See Page 23		196,190
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 516,878

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Adducci Vega Financial Group	Audit	$ 5,073
Community Service Partners	Data Processing	34,716
Paycor	Computer Payroll	18,496
Pretzel & Stouffer	Legal Expenses	22
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 58,307

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,405
Unemployment Compensation Insurance	10,807
FICA Taxes	220,705
Employee Health Insurance	258,549
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Match	9,786
Employee Medical Tests	10,645
Other Employee Benefits	1,621
Accrued Vacation Wages	16,659
TOTAL (agree to Schedule V, line 22, col.8)	$ 561,177

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 459
Advertising: Employee Recruitment	360
Health Care Worker Background Check	832
(Indicate # of checks performed)	
Misc Memberships	330
Association Dues (total from pg 22, #4)	12,410
Misc Subscriptions	626
Less: Public Relations Expense	( )
PAC and Lobbying payments	(8,645)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,372

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	334
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 334

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	3,765
	3,765 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	
Other: Clearbrook & UCP Seguin	5,583
Other: CARF International	2,877
Other, please specify Don Moss	185
	8,645 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	3,765
Other: Clearbrook & UCP Seguin	5,583
Other: CARF International	2,877
Other, please specify Don Moss	185
	12,410 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 49,054 Line 10

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 219,332
This amount is to be recorded on line 42 of Schedule V.

(8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(9) 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

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? No Indicate the amount. $

(12) 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. $

(13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Aducci Vega Financial Group

(14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule VIII. PartB

Central Office - 10833 S. Laporte Avenue occupies 1,717 square feet Administration and Accounting and Bookkeeping
This is 6.9% of total square footage of 24,693.
These costs are distributed to each program on the percentage of budget.
The Administrative salaries are distributed on the percentage of budget basis.

A. Administrative Salaries		Ownership	
Name	Function	%	Amount
Charles Carrell	HR Director		36,862
Paul Jordan	HR Assistant		26,812
Shellie Hubbart	HR Assistant		22,730
Fred Hausmann	Director of Finance		38,246
Julie Kurent	Staff Accountant		26,560
Kathy Dehlin	Staff Accountant		26,560
Kim Phelps	Reimb. Specialist		18,420
Total to Page 21			196,190