

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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 Facility ID Number: 0027052

Facility Name: LAKE PARK CENTER

Address: 919 WASHINGTON PARK WAUKEGAN 60085
 Number City Zip Code

County: LAKE

Telephone Number: (847) 623-9100 Fax # (847) 623-9179

IDPA ID Number: 36-3109638

Date of Initial License for Current Owners: 02/01/81

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
 Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 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) _____
	(Type or Print Name) <u>MORRIS ESFORMES</u> (Date) _____
Paid Preparer	(Title) <u>GENERAL PARTNER</u>
	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____
Paid Preparer	(Print Name and Title) <u>BOB KAGDA PARTNER</u>
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	210	Skilled (SNF)	210	76,650	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,650	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Public Aid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	70,534		3,432	73,966
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	70,534		3,432	73,966

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.50%

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

NONE

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 02/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/81 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: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	244,998	13,031	8,775	266,804		266,804		266,804		1
2	Food Purchase		196,459		196,459	(6,205)	190,254	(1,180)	189,074		2
3	Housekeeping	175,716	35,385		211,101		211,101		211,101		3
4	Laundry	94,751	12,579	1,654	108,984		108,984		108,984		4
5	Heat and Other Utilities			170,555	170,555		170,555	600	171,155		5
6	Maintenance	105,272	8,835	30,031	144,138		144,138	(2,569)	141,569		6
7	Other (specify):*			13,858	13,858		13,858	43	13,901		7
8	TOTAL General Services	620,737	266,289	224,873	1,111,899	(6,205)	1,105,694	(3,106)	1,102,588		8
	B. Health Care and Programs										
9	Medical Director			3,840	3,840		3,840		3,840		9
10	Nursing and Medical Records	2,074,638	163,749	26,213	2,264,600		2,264,600		2,264,600		10
10a	Therapy	81,515		5,827	87,342		87,342		87,342		10a
11	Activities	93,575	3,321	4,743	101,639		101,639		101,639		11
12	Social Services			405	405		405		405		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,249,728	167,070	41,028	2,457,826		2,457,826		2,457,826		16
	C. General Administration										
17	Administrative	96,000		515,000	611,000		611,000	(491,665)	119,335		17
18	Directors Fees										18
19	Professional Services			41,101	41,101		41,101	9,887	50,988		19
20	Dues, Fees, Subscriptions & Promotions			19,993	19,993		19,993	(4,009)	15,984		20
21	Clerical & General Office Expenses	61,346	16,394	167,184	244,924		244,924	(112,389)	132,535		21
22	Employee Benefits & Payroll Taxes			460,446	460,446	6,205	466,651		466,651		22
23	Inservice Training & Education			1,925	1,925		1,925	41	1,966		23
24	Travel and Seminar			3,622	3,622		3,622		3,622		24
25	Other Admin. Staff Transportation			61,613	61,613		61,613	775	62,388		25
26	Insurance-Prop.Liab.Malpractice			108,318	108,318		108,318	1,035	109,353		26
27	Other (specify):*							6,805	6,805		27
28	TOTAL General Administration	157,346	16,394	1,379,202	1,552,942	6,205	1,559,147	(589,520)	969,627		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,027,811	449,753	1,645,103	5,122,667		5,122,667	(592,626)	4,530,041		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,160
	REPAIRS & MAINTENANCE	615
		0
		8,775
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,654
		0
		1,654
5	HEAT & OTHER UTILITIES	
	GAS HEAT	55,622
	ELECTRICITY	58,346
	WATER	56,587
	CABLE TV - LOBBY	0
		0
		170,555
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,209
	PAINTING & DECORATING	7,319
	BUILDING REPAIRS	3,160
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,506
	ELEVATOR MAINTENANCE & REPAIR	5,897
	OUTSIDE LABOR	500
	EXTERMINATING SERVICE	2,861
	FIRE SERVICE	4,579
		0
		0
		0
		30,031
7	OTHER	
	SCAVENGER	8,458
	SECURITY SERVICE	5,400
		0
		13,858
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,840
		0
		3,840

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	7,767
	PURCHASED SERVICES	1,769
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	8,467
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	4,735
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	3,475
		0
		26,213
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	2,665
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	3,162
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		5,827
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,743
		0
		4,743
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	405
	SOCIAL WORKER XVIII B 45-2	0
		0
		405
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	515,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	15,727
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	25,374
		0
		41,101
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	6,127
	CONTRIBUTIONS VI 20 XIX F	1,000
	DUES & SUBSCRIPTIONS XIX F	7,848
	LICENSES & PERMITS XIX F	0
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	175
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	1,125
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,358
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,360
		19,993
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,125
	EQUIPMENT REPAIR & MAINTENANCE	2,143
	OUTSIDE CLERICAL SERVICES	127,790
	PENALTIES / OVERDRAFT CHARGES VI 18	158
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,628
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	19,340
		167,184

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	230,116
	UNEMPLOYMENT COMPENSATION XIX D	13,165
	WORKERS COMPENSATION INSURANCE XIX D	70,262
	HOSPITALIZATION INSURANCE XIX D	108,735
	EMPLOYEE BENEFITS - OTHER XIX D	500
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	37,668
	CHICAGO HEAD TAX XIX D	0
		460,446
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,925
		1,925
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	3,622
		0
		0
		3,622
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	61,613
		61,613
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE 108,318	108,318
		108,318
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

1,645,103

Facility Name & ID Number LAKE PARK CENTER

#0027052

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			150,950	150,950		150,950	(19,036)	131,914			30
31	Amortization of Pre-Op. & Org.			2,257	2,257		2,257		2,257			31
32	Interest			90,977	90,977		90,977	2,488	93,465			32
33	Real Estate Taxes			133,467	133,467		133,467	3,095	136,562			33
34	Rent-Facility & Grounds			289,364	289,364		289,364		289,364			34
35	Rent-Equipment & Vehicles			29,999	29,999		29,999	5,788	35,787			35
36	Other (specify):* OFFICE RENT			16,380	16,380		16,380	(16,380)				36
37	TOTAL Ownership			713,394	713,394		713,394	(24,045)	689,349			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			114,975	114,975		114,975		114,975			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			114,975	114,975		114,975		114,975			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,027,811	449,753	2,473,472	5,951,036		5,951,036	(616,671)	5,334,365			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 LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	(20,936)	30		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	(1,180)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,125)	20		17
18	Fines and Penalties	(158)	21		18
19	Entertainment		20		19
20	Contributions	(3,358)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(175)	20		28
29	Other-Attach Schedule	(25,439)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,371)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(564,300)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (564,300)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (616,671)		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

LAKE PARK CENTER

ID# 0027052

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (6,099)	6	1
2	STAFF DEVELOPMENT	(19,340)	21	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
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	(25,439)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,180)	0	0	0	0	0	0	0	0	0	0	(1,180)	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	600	0	0	0	0	0	0	0	0	0	600	5
6	Maintenance	(6,099)	958	2,572	0	0	0	0	0	0	0	0	(2,569)	6
7	Other (specify):*	0	0	43	0	0	0	0	0	0	0	0	43	7
8	TOTAL General Services	(7,279)	1,558	2,615	0	0	0	0	0	0	0	0	(3,106)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	7,869	(499,534)	0	0	0	0	0	0	0	(491,665)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	255	9,433	199	0	0	0	0	0	0	0	9,887	19
20	Fees, Subscriptions & Promotions	(4,658)	0	649	0	0	0	0	0	0	0	0	(4,009)	20
21	Clerical & General Office Expenses	(19,498)	121	(101,258)	8,246	0	0	0	0	0	0	0	(112,389)	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	41	0	0	0	0	0	0	0	0	41	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	537	238	0	0	0	0	0	0	0	775	25
26	Insurance-Prop.Liab.Malpractice	0	121	729	185	0	0	0	0	0	0	0	1,035	26
27	Other (specify):*	0	0	4,176	2,629	0	0	0	0	0	0	0	6,805	27
28	TOTAL General Administration	(24,156)	497	(77,824)	(488,037)	0	(589,520)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,435)	2,055	(75,209)	(488,037)	0	(592,626)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(20,936)	1,614	286	0	0	0	0	0	0	0	0	(19,036)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,488	0	0	0	0	0	0	0	0	0	2,488	32
33	Real Estate Taxes	0	3,095	0	0	0	0	0	0	0	0	0	3,095	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	151	4,489	1,148	0	0	0	0	0	0	0	5,788	35
36	Other (specify):*	0	(16,380)	0	0	0	0	0	0	0	0	0	(16,380)	36
37	TOTAL Ownership	(20,936)	(9,032)	4,775	1,148	0	(24,045)	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)	(52,371)	(6,977)	(70,434)	(486,889)	0	(616,671)	45						

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
SEE ATTACHED		SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISES	LINCOLNWOOD	CONSULTANT
				IME REALTY CORP.	LINCOLNWOOD	HOME OFFICE

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	36 OFFICE RENT	\$ 16,380	IME REALTY CORP.		\$	(16,380)	1
2	V	5 UTILITIES		"		600	600	2
3	V	6 REPAIRS/MAINT		"		958	958	3
4	V	19 PROFESSIONAL FEES		"		255	255	4
5	V	21 OFFICE EXPENSE		"		121	121	5
6	V	26 INSURANCE		"		121	121	6
7	V	30 DEPRECIATION (SL)		"		1,614	1,614	7
8	V	32 INTEREST		"		2,488	2,488	8
9	V	33 RE TAXES		"		3,095	3,095	9
10	V	35 STORAGE FEES		"		151	151	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 16,380			\$ 9,403	\$ * (6,977)	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 OUTSIDE CLERICAL	\$ 127,790	EKS MANAGEMENT CO.		\$	(127,790)
16	V	6 PAINTERS SALARIES		"		2,572	2,572
17	V	7 SCAVENGER		"		43	43
18	V	17 CFO SALARY		"		7,869	7,869
19	V	19 PROFESSIONAL FEES		"		9,433	9,433
20	V	20 WANT ADS/BACKGR CKS		"		649	649
21	V	21 TOTAL OFFICE		"		26,532	26,532
22	V	23 SEMINARS		"		41	41
23	V	25 TRANSPORTATION		"		537	537
24	V	26 INSURANCE		"		729	729
25	V	27 EMPLOYEE BENEFITS		"		4,176	4,176
26	V	30 DEPRECIATION (SL)		"		286	286
27	V	35 EQUIPMENT RENT		"		4,489	4,489
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 127,790			\$ 57,356	\$ * (70,434)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 515,000	EMI ENTERPRISES INC.		\$	(515,000)
16	V	17 OFFICERS SALARY		"		15,466	15,466
17	V	19 ACCOUNTING FEES		"		199	199
18	V	21 TOTAL OFFICE		"		8,246	8,246
19	V	25 TRANSPORTATION		"		238	238
20	V	26 INSURANCE		"		185	185
21	V	27 EMPLOYEE BENEFITS		"		2,629	2,629
22	V	35 AUTO LEASE		"		1,148	1,148
23	V			"			
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 515,000			\$ 28,111	\$ * (486,889)

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

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	MORRIS ESFORMES	GENERAL PTR.	ADMINISTRAT.	47.62		SEE ATTACHED		SALARY	\$ 15,466	17-8	1
2	AVRUM WEINFELD	CFO	CFO	1.43		SCHEDULE		SALARY	7,869	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,335		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 LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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 EKS MANAGEMENT
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	PATIENT DAYS	884,739	14	\$ 30,769	\$ 73,966	\$ 2,572	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510	73,966	43	2
3	17	CFO SALARY	PATIENT DAYS	884,739	14	94,128	73,966	7,869	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835	83,281	9,433	4
5	20	WANT ADS / BACKGR CKS	PATIENT DAYS	884,739	14	7,759	73,966	649	5
6	21	TOTAL OFFICE	PATIENT DAYS	884,739	14	317,364	228,335	26,532	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490	73,966	41	7
8	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427	73,966	537	8
9	26	INSURANCE	PATIENT DAYS	884,739	14	8,715	73,966	729	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951	73,966	4,176	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	884,739	14	3,418	73,966	286	11
12	35	EQUIPMENT RENT	PATIENT DAYS	884,739	14	53,700	73,966	4,489	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					\$ 686,066	\$ 311,616	\$ 57,356	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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 IME REALTY CORP.
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 675-5795
 Fax Number (847) 674-5794

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	5	UTILITIES	PATIENT DAYS	303,433	15	\$ 11,111	\$ 16,380	\$ 600	1
2	6	REPAIRS/MAINT	PATIENT DAYS	303,433	15	17,749	16,380	958	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	303,433	15	4,725	16,380	255	3
4	21	OFFICE EXPENSE	PATIENT DAYS	303,433	15	2,247	16,380	121	4
5	26	INSURANCE	PATIENT DAYS	303,433	15	2,237	16,380	121	5
6	30	DEPRECIATION (SL)	PATIENT DAYS	303,433	15	29,895	16,380	1,614	6
7	32	INTEREST	PATIENT DAYS	303,433	15	46,095	16,380	2,488	7
8	33	RE TAX	PATIENT DAYS	303,433	15	57,331	16,380	3,095	8
9	35	STORAGE FEES	PATIENT DAYS	303,433	15	2,800	16,380	151	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					\$ 174,190	\$	\$ 9,403	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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 EMI ENTERPRISES, INC.
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-5795
 Fax Number (847) 674-5794

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	17	OFFICERS SALARY	PATIENT DAYS	884,739	14	\$ 185,000	\$ 73,966	\$ 15,466	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381	73,966	199	2
3	21	TOTAL OFFICE	PATIENT DAYS	884,739	14	98,637	73,966	8,246	3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845	73,966	238	4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2,209	73,966	185	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442	73,966	2,629	6
7	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730	73,966	1,148	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					\$ 336,244	\$ 261,255	\$ 28,111	25

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	MB FINANCIAL		X	MORTGAGE	\$38,936.00	09/05/03	\$ 7,300,000	\$ 7,271,561	09/05/08	4.0000	\$ 70,522	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	CIB BANK		X	WORKING CAPITAL	DEMAND	01/02	500,000			PPRIME+	20,455	6						
7												7						
8	MGMT CO ALLOCATION										2,488	8						
9	TOTAL Facility Related				\$38,936.00		\$ 7,800,000	\$ 7,271,561			\$ 93,465	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 7,800,000	\$ 7,271,561			\$ 93,465	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	\$	110,149	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.)	\$	121,202	2
3. Under or (over) accrual (line 2 minus line 1).	\$	11,053	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	122,414	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.	\$	133,467	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	88,969	8
	1999	88,164	9
	2000	91,441	10
	2001	107,989	11
	2002	121,202	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 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, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE PARK CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027052

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-29-400-032</u>	<u>NURSING HOME</u>	\$ <u>121,201.80</u>	\$ <u>121,201.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>121,201.80</u>	\$ <u>121,201.80</u>

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 X NO

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

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,175 B. General Construction Type: Exterior BRICK Frame CONCRETE 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>2003</u>	<u>\$ 1,050,000</u>	1
2					2
3	TOTALS			\$ 1,050,000	3

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	210	2003	1967	\$ 8,144,786	\$ 61,703	27.5	\$ 61,703	\$	\$ 61,703	4
5										5
6										6
7										7
8	IME ALLOCATION				1,579		1,579			8
	Improvement Type**									
9	PAINTING		1986	15,680		15	1,118	1,118	15,680	9
10	ASHALT PAVING		1987	8,180	260	31.5	200	(60)	8,180	10
11	AVAC UNITS		1988	45,000	1,429	31.5	1,429		33,421	11
12	ROOFING		1989	56,815	1,804	31.5	1,804		25,557	12
13	CUBICLE CURTAIN & TILE		1991	20,473	650	31.5	650		8,098	13
14	PARKING LOTS		1993	19,440	1,296	15	1,296		13,292	14
15	CUBICLE CURTAINS		1993	1,796	46	31.5	46		558	15
16	NURSE STATION		1993	7,800	200	31.5	200		2,422	16
17	ELEVATOR		1994	22,300	572	39	572		5,410	17
18	CUBICLE CURTAINS		1994	843	22	39	22		215	18
19	PARKING LOTS LIGHTS		1995	8,677	578	15	578		4,913	19
20	REPAIR STONE FASCIA		1995	9,750	250	39	250		2,115	20
21	INSULATE SUPPLY/DUCT WORK		1995	7,190	185	39	185		1,510	21
22	TILE		1996	20,387	522	39	522		3,808	22
23	WEATHER-ROOFTOP		1997	6,408	164	39	164		991	23
24	METAL DOORS & AIR CONDITION		1998	11,993	308	39	308		1,809	24
25	TWO SHOWERS		1998	2,720	70	39	70		405	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN		1998	9,800	251	39	251		1,370	26
27	CABINERY-ADM., BOOKKEPING, DON		1998	33,000	846	39	846		4,477	27
28	WATER HEATER		1998	4,639	119	39	119		610	28
29	INSTALLED SMOKE AND DUST DETECTORS		1999	4,572	117	39	117		532	29
30	FURNISH AND INSTALL FIRE DAMPERS		1999	25,971	666	39	666		2,914	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE		1999	18,547	476	39	476		1,924	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK		1999	8,640	222	39	222		916	32
33	FIRE DAMPERS		2000	8,070	293	20	293		1,038	33
34	FENCE		2000	6,810	477	15	477		1,484	34
35	CUBICLE CURTAINS		2001	14,018	2,691	20	701	(1,990)	2,103	35
36	ROOF MAINTENANCE & FLASHING REPAIR		2001	6,950	253	27.5	253		759	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.

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	PAINT ALL INTERIOR WALLS	2001	\$ 2,800	\$ 102	27.5	\$ 102	\$	\$ 306	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895	8,620	20	2,245	(6,375)	6,735	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		3,144	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		1,407	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		1,438	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)		\$ 8,675,814	\$ 89,566		\$ 82,259	\$ (7,307)	\$ 221,244	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 287,771	\$ 41,963	\$ 28,334	\$ (13,629)	5-10 YR	\$ 126,179	71
72	Current Year Purchases	420,000	21,000	21,000		5-10 YR	21,000	72
73	Fully Depreciated Assets	225,668					225,668	73
74	EKS,IME ALLOCATION		321	321				74
75	TOTALS	\$ 933,439	\$ 63,284	\$ 49,655	\$ (13,629)		\$ 372,847	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				\$	\$	\$	\$		\$	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)	\$ 10,659,253	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,850	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,914	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,936)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 594,091	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: WAUKEGAN HEALTH CARE INC.

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1967</u>	<u>210</u>		\$ <u>289,364</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>210</u>		\$ <u>289,364</u>			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: \$ 13,139 Description: SEE SCHEDULE ATTACHED

(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>FACILITY</u>	<u>2001 CHEVY VAN</u>	\$ <u>699.00</u>	\$ <u>9,784</u>	17
18	<u>MAINTENANCE</u>	<u>2001 FORD TRUCK</u>	<u>594.00</u>	<u>7,076</u>	18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>16,860</u>	21

10. Effective dates of current rental agreement:

Beginning 02/01/86

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED		
1. From this facility		
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 aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			N/A			#VALUE!	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			\$		\$	\$		\$	#VALUE!

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

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(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	\$ 144,165	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	946,906		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	111,436		6
7	Other Prepaid Expenses	9,660		7
8	Accounts Receivable (owners or related parties)	457,812		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	81,609		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,751,588	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,050,000		13
14	Buildings, at Historical Cost	8,144,786		14
15	Leasehold Improvements, at Historical Cost	531,028		15
16	Equipment, at Historical Cost	933,439		16
17	Accumulated Depreciation (book methods)	(711,177)		17
18	Deferred Charges	45,149		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): <u>Amort of Def Mortgage Costs</u>	(2,257)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,990,968	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,742,556	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 153,365	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	180		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,707		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,885		31
32	Accrued Real Estate Taxes(Sch.IX-B)	122,414		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 410,551	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,348,451		39
40	Mortgage Payable	7,271,561		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)	\$ 9,620,012	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,030,563	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,711,993	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,742,556	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,759,488	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,759,486	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	927,907	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	(975,400)	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)	\$ (47,493)	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)	\$ 1,711,993	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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	\$ 6,893,412	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,893,412	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 73	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)	\$ 6,893,485	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,111,899	31
32	Health Care	2,457,826	32
33	General Administration	1,552,942	33
	B. Capital Expense		
34	Ownership	713,394	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	114,975	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,951,036	40
41	Income before Income Taxes (line 30 minus line 40)**	942,449	41
42	Income Taxes	(14,542)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 927,907	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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 LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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	2,026	2,281	\$ 76,153	\$ 33.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,485	20,171	519,441	25.75	3
4	Licensed Practical Nurses	8,695	9,183	213,881	23.29	4
5	Nurse Aides & Orderlies	109,584	113,666	1,229,494	10.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,157	6,565	81,515	12.42	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,292	9,673	93,575	9.67	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,103	26,178	244,998	9.36	15
16	Dishwashers					16
17	Maintenance Workers	7,552	7,844	105,272	13.42	17
18	Housekeepers	22,521	23,423	175,716	7.50	18
19	Laundry	10,228	10,611	94,751	8.93	19
20	Administrator	2,033	2,033	96,000	47.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,478	6,641	61,346	9.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Quality Assurance</u>	2,679	2,746	35,669	12.99	33
34	TOTAL (lines 1 - 33)	231,833	241,015	\$ 3,027,811 *	\$ 12.56	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	\$ 8,160	1-3	35
36	Medical Director	Monthly Fee 3,840	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	Monthly Fee 8,467	10-3	39
40	Physical Therapy Consultant	52 2,665	10a-3	40
41	Occupational Therapy Consultant	62 3,162	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	93 4,743	11-3	44
45	Social Service Consultant	8 405	12-3	45
46	Other(specify)			46
47	<u>PSYCHIATRIC</u>	Monthly Fee 4,735	10-3	47
48	<u>DENTAL</u>	Monthly Fee 3,475	10-3	48
49	TOTAL (lines 35 - 48)	215 \$ 39,652		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$	10-3	50
51	Licensed Practical Nurses	N/A	10-3	51
52	Nurse Aides		10-3	52
53	TOTAL (lines 50 - 52)	\$		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	
BRIAN LIVINGS	ADMIN	0	\$ 96,000	Workers' Compensation Insurance	\$ 70,262	IDPH License Fee	\$	
				Unemployment Compensation Insurance	13,165	Advertising: Employee Recruitment	6,127	
				FICA Taxes	230,116	Health Care Worker Background Check	1,360	
				Employee Health Insurance	108,735	(Indicate # of checks performed _____)		
				Employee Meals	#REF!	MARKETING/ADV/PROMO	175	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,483	
				EMPLOYEE BENEFITS - OTHER	500	LICENSES & PERMITS	0	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	7,848	
				PENSION/PROFIT SHARING PLANS	37,668	MGMT CO ALLOCATION	649	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,483)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(175)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ #REF!		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
EMI ENTERPRISES, INC MANAGEMENT FEES			\$ 515,000				Out-of-State Travel	\$
							FLORIDA	3,622
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 515,000				Seminar Expense	
								0
C. Professional Services				TOTAL			Entertainment Expense (_____)	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
ALPHA DATA	DATA PROCESSING		\$ 4,006				TOTAL	
LTC SOLUTIONS	DATA PROCESSING		1,320				\$ 3,622	
MAXXSOURCE	DATA PROCESSING		1,380					
NCS	DATA PROCESSING		9,022					
KBKB	ACCOUNTING		11,100					
STONE, MCGUIRE, BENJAMIN	LEGAL		2,248					
HOLLAND & KNIGHT	LEGAL		10,940					
CSC	LEGAL		128					
PERSONNEL PLANNERS	U.C. CONSULTANT		957					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 41,101					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINING/DECORATING	1999	\$ 3,934	3 YRS	\$ 1,311	\$ 1,311	\$ 656	\$	\$	\$	\$	\$												
2	PAINING/DECORATING	2003	7,319	3 YRS				1,220	2,440	2,440	1,219													
3																								
4																								
5																								
6																								
7																								
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18																								
19																								
20	TOTALS		\$ 11,253		\$ 1,311	\$ 1,311	\$ 656	\$ 1,220	\$ 2,440	\$ 2,440	\$ 1,219	\$												

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$7848
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 144 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 114,975
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? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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? YES
Attach invoices and a summary of services for all architect and appraisal fees