

		FOR OHF USE					

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**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)**

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.

<p>I. IDPH Facility ID Number: <u>0027052</u></p> <p>Facility Name: <u>LAKE PARK CENTER</u></p> <p>Address: <u>919 WASHINGTON PARK</u> <u>WAUKEGAN</u> <u>60085</u> Number City Zip Code</p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>(847) 623-9100</u> Fax # <u>(847) 623-9179</u></p> <p>IDPA ID Number: <u>36-3109638</u></p> <p>Date of Initial License for Current Owners: <u>02/01/81</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MORRIS ESFORMES</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>GENERAL PARTNER</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MORRIS ESFORMES</u>			(Title) <u>GENERAL PARTNER</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	72,530	435	1,750	74,715	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,530	435	1,750	74,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.48%

D. How many bed-hold days during this year were paid by the Department? _____ (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: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **LAKE PARK CENTER** # **0027052** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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	265,197	15,829	9,653	290,679		290,679		290,679		1
2	Food Purchase		199,104		199,104	(9,198)	189,906	(605)	189,301		2
3	Housekeeping	161,806	67,084		228,890		228,890		228,890		3
4	Laundry	99,870	18,108		117,978		117,978	1,623	119,601		4
5	Heat and Other Utilities			187,474	187,474		187,474	455	187,929		5
6	Maintenance	137,982	16,797	31,580	186,359		186,359	3,276	189,635		6
7	Other (specify):*			15,237	15,237		15,237	97	15,334		7
8	TOTAL General Services	664,855	316,922	243,944	1,225,721	(9,198)	1,216,523	4,846	1,221,369		8
	B. Health Care and Programs										
9	Medical Director			5,200	5,200		5,200		5,200		9
10	Nursing and Medical Records	2,307,239	124,266	15,903	2,447,408		2,447,408		2,447,408		10
10a	Therapy	52,109		4,884	56,993		56,993		56,993		10a
11	Activities	95,377	4,613	424	100,414		100,414		100,414		11
12	Social Services			1,755	1,755		1,755		1,755		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,454,725	128,879	28,166	2,611,770		2,611,770		2,611,770		16
	C. General Administration										
17	Administrative	98,800		371,000	469,800		469,800	(346,996)	122,804		17
18	Directors Fees										18
19	Professional Services			37,141	37,141		37,141	13,039	50,180		19
20	Dues, Fees, Subscriptions & Promotions			14,261	14,261		14,261	(1,240)	13,021		20
21	Clerical & General Office Expenses	119,521	22,291	144,279	286,091		286,091	(93,655)	192,436		21
22	Employee Benefits & Payroll Taxes			407,700	407,700	9,198	416,898		416,898		22
23	Inservice Training & Education							31	31		23
24	Travel and Seminar			3,335	3,335		3,335		3,335		24
25	Other Admin. Staff Transportation			8,999	8,999		8,999	638	9,637		25
26	Insurance-Prop.Liab.Malpractice			87,529	87,529		87,529	3,064	90,593		26
27	Other (specify):*			283,998	283,998		283,998	(275,678)	8,320		27
28	TOTAL General Administration	218,321	22,291	1,358,242	1,598,854	9,198	1,608,052	(700,797)	907,255		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,337,901	468,092	1,630,352	5,436,345		5,436,345	(695,951)	4,740,394		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	8,790
	REPAIRS & MAINTENANCE		863
			0
			9,653
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		74,591
	ELECTRICITY		52,946
	WATER		59,324
	CABLE TV - LOBBY		613
			0
			187,474
6	MAINTENANCE		
	GROUNDS MAINTENANCE		7,350
	PAINTING & DECORATING		6,508
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		4,174
	ELEVATOR MAINTENANCE & REPAIR		6,880
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,043
	FIRE SERVICE		3,625
			0
			0
			0
			31,580
7	OTHER		
	SCAVENGER		9,837
	SECURITY SERVICE		5,400
			15,237
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,200
			5,200

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		300
	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	7,928
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	3,400
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL		4,275
			0
			15,903
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,822
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,062
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			4,884
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	424
			0
			424
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,755
	SOCIAL WORKER	XVIII B 45-2	0
			0
			1,755
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	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	371,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,074
	ADMINISTRATIVE CONSULTANTS XIX C	6,000
	PROFESSIONAL FEES XIX C	17,067
		0
		37,141
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	3,042
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,527
	LICENSES & PERMITS XIX F	0
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	703
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,679
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	310
		14,261
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	105,600
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,423
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	25,256
		144,279

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	245,611
	UNEMPLOYMENT COMPENSATION XIX D	29,678
	WORKERS COMPENSATION INSURANCE XIX D	37,688
	HOSPITALIZATION INSURANCE XIX D	63,973
	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	30,250
	CHICAGO HEAD TAX XIX D	0
		407,700
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,955
	TRAVEL XIX G	1,380
		0
		0
		3,335
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,999
		8,999
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	87,529
		87,529
27	OTHER	
	BAD DEBTS VI 24	283,998
		283,998

GRAND TOTAL COLUMN 3 OTHER

1,630,352

LAKE PARK CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	199,104	PATIENT MEALS	224145
LESS SALES TAX	(605)	ADD EMPLOYEE MEALS	10950
	-----		-----
NET FOOD	198,499	TOTAL MEALS/YEAR	235095
TOTAL PATIENT CENSUS	74,715	NET FOOD	198499
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	235095

TOTAL PATIENT MEALS	224145	COST PER MEAL	0.84
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	9198
	-----		=====
TOTAL EMPLOYEE MEALS	10950		

Facility Name & ID Number

LAKE PARK CENTER

#0027052

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			74,107	74,107		74,107	377,503	451,610			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,273	26,273		26,273	620,412	646,685			32
33	Real Estate Taxes							127,164	127,164			33
34	Rent-Facility & Grounds			873,000	873,000		873,000	(873,000)				34
35	Rent-Equipment & Vehicles			28,135	28,135		28,135	6,076	34,211			35
36	Other (specify):* OFFICE RENT			16,380	16,380		16,380	(16,380)				36
37	TOTAL Ownership			1,017,895	1,017,895		1,017,895	241,775	1,259,670			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)	3,337,901	468,092	2,763,222	6,569,215		6,569,215	(454,176)	6,115,039			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:

01/01/2005

Ending:

12/31/2005

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	(16,170)	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	(605)	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		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,679)	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	(283,998)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(703)	20		28
29	Other-Attach Schedule SEE PAGE 5-A	(25,030)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (328,185)		\$	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)	(125,991)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (125,991)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (454,176)		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: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 226	6	1
2	STAFF DEVELOPMENT	(25,256)	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	(25,030)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(605)	0	0	0	0	0	0	0	0	0	0	(605)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,623	0	0	0	0	0	0	0	0	1,623	4
5	Heat and Other Utilities	0	455	0	0	0	0	0	0	0	0	0	455	5
6	Maintenance	226	902	2,148	0	0	0	0	0	0	0	0	3,276	6
7	Other (specify):*	0	50	47	0	0	0	0	0	0	0	0	97	7
8	TOTAL General Services	(379)	1,407	3,818	0	0	0	0	0	0	0	0	4,846	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	8,676	(355,672)	0	0	0	0	0	0	0	(346,996)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	74	12,408	557	0	0	0	0	0	0	0	13,039	19
20	Fees, Subscriptions & Promotions	(2,382)	0	1,142	0	0	0	0	0	0	0	0	(1,240)	20
21	Clerical & General Office Expenses	(25,256)	363	(76,867)	8,105	0	0	0	0	0	0	0	(93,655)	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	31	0	0	0	0	0	0	0	0	31	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	546	92	0	0	0	0	0	0	0	638	25
26	Insurance-Prop.Liab.Malpractice	0	275	2,560	229	0	0	0	0	0	0	0	3,064	26
27	Other (specify):*	(283,998)	0	5,835	2,485	0	0	0	0	0	0	0	(275,678)	27
28	TOTAL General Administration	(311,636)	712	(45,669)	(344,204)	0	(700,797)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(312,015)	2,119	(41,851)	(344,204)	0	(695,951)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,170)	1,439	300	391,934	0	0	0	0	0	0	0	377,503	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,389	0	618,023	0	0	0	0	0	0	0	620,412	32
33	Real Estate Taxes	0	2,240	0	124,924	0	0	0	0	0	0	0	127,164	33
34	Rent-Facility & Grounds	0	0	0	(873,000)	0	0	0	0	0	0	0	(873,000)	34
35	Rent-Equipment & Vehicles	0	321	5,290	465	0	0	0	0	0	0	0	6,076	35
36	Other (specify):*	0	(16,380)	0	0	0	0	0	0	0	0	0	(16,380)	36
37	TOTAL Ownership	(16,170)	(9,991)	5,590	262,346	0	241,775	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)	(328,185)	(7,872)	(36,261)	(81,858)	0	(454,176)	45						

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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
				EKS MANAGEMENT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISES	LINCOLNWOOD	CONSULTANT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		IME REALTY CORP.	LINCOLNWOOD	HOME OFFICE
				WAUKEGAN PRO- PERTIES, LLC	LINCOLNWOOD	REAL ESTATE

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)	
1	V	36 OFFICE RENT	\$ 16,380	IME REALTY CORP.		\$	(16,380)	1
2	V	5 UTILITIES		"		455	455	2
3	V	6 REPAIRS/MAINT		"		902	902	3
4	V	19 PROFESSIONAL FEES		"		74	74	4
5	V	21 OFFICE EXPENSE		"		363	363	5
6	V	26 INSURANCE		"		275	275	6
7	V	30 DEPRECIATION (SL)		"		1,439	1,439	7
8	V	32 INTEREST		"		2,389	2,389	8
9	V	33 RE TAXES		"		2,240	2,240	9
10	V	35 STORAGE FEES		"		321	321	10
11	V	7 ALARM SERVICE		"		50	50	11
12	V							12
13	V							13
14	Total		\$ 16,380			\$ 8,508	\$ * (7,872)	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	\$ 105,600	EKS MANAGEMENT CO.		\$	(105,600)
16	V	6 PAINTERS SALARIES		" " "		2,148	2,148
17	V	7 SCAVENGER		" " "		47	47
18	V	17 CFO SALARY		" " "		8,676	8,676
19	V	19 PROFESSIONAL FEES		" " "		12,408	12,408
20	V	20 WANT ADS/BACKGR CKS		" " "		1,142	1,142
21	V	21 TOTAL OFFICE		" " "		28,733	28,733
22	V	23 SEMINARS		" " "		31	31
23	V	25 TRANSPORTATION		" " "		546	546
24	V	26 INSURANCE		" " "		2,560	2,560
25	V	27 EMPLOYEE BENEFITS		" " "		5,835	5,835
26	V	30 DEPRECIATION (SL)		" " "		300	300
27	V	35 EQUIPMENT RENT		" " "		5,290	5,290
28	V	4 HOUSEKEEPING SALARIES		" " "		1,611	1,611
29	V	4 CLEANING SUPPLIES		" " "		12	12
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 105,600			\$ 69,339	\$ * (36,261)

* 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	\$ 371,000	EMI ENTERPRISES INC.		\$	\$(371,000)
16	V	17 OFFICERS SALARY		" " "		15,328	15,328
17	V	19 ACCOUNTING FEES		" " "		557	557
18	V	21 TOTAL OFFICE		" " "		8,105	8,105
19	V	25 TRANSPORTATION		" " "		92	92
20	V	35 AUTO LEASE		" " "		465	465
21	V	27 EMPLOYEE BENEFITS		" " "		2,485	2,485
22	V	26 INSURANCE		" " "		229	229
23	V						
24	V						
25	V						
26	V						
27	V	34 RENT	873,000	WAUKEGAN TERRACE PROPERTIES LLC			\$(873,000)
28	V	33 REAL ESTATE TAX		" " " "		124,924	124,924
29	V	30 DEPRECIATION (SL)		" " " "		391,934	391,934
30	V	32 INTEREST		" " " "		618,023	618,023
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,244,000			\$ 1,162,142	\$ * (81,858)

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

Facility Name & ID Number

LAKE PARK CENTER

#

0027052

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	ADMINISTRATIV	47.62		SEE ATTACHED		SALARY	\$ 15,328	17-8	1
2	AVRUM WEINFELD	CFO	CFO	1.43		SCHEDULE		SALARY	8,676	17-8	2
3	PHILLIP ESFORMES	CONSULTANT	ADMINISTRATIV	0.00				SALARY	6,000	19-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 30,004		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:

01/01/2005

Ending: 2/31/2005

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 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	6	PAINTERS SALARIES	PATIENT DAYS	15	\$ 25,925	\$	74,715	\$ 2,148	1
2	7	SCAVENGER	PATIENT DAYS	15	573		74,715	47	2
3	17	CFO SALARY	PATIENT DAYS	15	104,714	104,714	74,715	8,676	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	15	149,759	119,638	74,715	12,408	4
5	20	WANT ADS / BACKGR CKS	PATIENT DAYS	15	13,787		74,715	1,142	5
6	21	TOTAL OFFICE	PATIENT DAYS	15	346,792	248,929	74,715	28,733	6
7	23	SEMINARS	PATIENT DAYS	15	380		74,715	31	7
8	25	TRANSPORTATION	PATIENT DAYS	15	6,593		74,715	546	8
9	26	INSURANCE	PATIENT DAYS	15	30,900		74,715	2,560	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	15	70,423		74,715	5,835	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	15	3,617		74,715	300	11
12	35	EQUIPMENT RENT	PATIENT DAYS	15	63,848		74,715	5,290	12
13	4	HOUSEKEEPING SALARIES	PATIENT DAYS	15	19,441		74,715	1,611	13
14	4	CLEANING SUPPLIES	PATIENT DAYS	15	140		74,715	12	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 836,892	\$ 473,281		\$ 69,339	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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	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	5	UTILITIES	PATIENT DAYS	346,361	15	\$ 9,618	\$ 16,380	\$ 455	1
2	6	REPAIRS/MAINT	PATIENT DAYS	346,361	15	19,083	16,380	902	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	346,361	15	1,575	16,380	74	3
4	21	OFFICE EXPENSE	PATIENT DAYS	346,361	15	7,666	16,380	363	4
5	26	INSURANCE	PATIENT DAYS	346,361	15	5,806	16,380	275	5
6	30	DEPRECIATION (SL)	PATIENT DAYS	346,361	15	30,446	16,380	1,439	6
7	32	INTEREST	PATIENT DAYS	346,361	15	50,514	16,380	2,389	7
8	33	RE TAX	PATIENT DAYS	346,361	15	47,364	16,380	2,240	8
9	35	STORAGE FEES	PATIENT DAYS	346,361	15	6,785	16,380	321	9
10	7	ALARM SERVICE	PATIENT DAYS	346,361	15	1,056	16,380	50	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					\$ 179,913	\$	\$ 8,508	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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	901,761	15	\$ 185,000	\$ 74,715	\$ 15,328	1
2	19	ACCOUNTING FEES	PATIENT DAYS	901,761	15	6,725	74,715	557	2
3	21	TOTAL OFFICE	PATIENT DAYS	901,761	15	97,823	74,715	8,105	3
4	25	TRANSPORTATION	PATIENT DAYS	901,761	15	1,114	74,715	92	4
5	35	AUTO LEASE	PATIENT DAYS	901,761	15	5,617	74,715	465	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	901,761	15	29,997	74,715	2,485	6
7	26	INSURANCE	PATIENT DAYS	901,761	15	2,768	74,715	229	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					\$ 329,044	\$ 264,576	\$ 27,261	25

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	RELATED PARTY: WAUKEGAN TERRACE PROPERTIES, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$75,123.97	04/04	10,324,600	10,056,385	04/39	5.1400	612,052	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		196,242	185,792			5,971	3						
4												4						
5												5						
Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND		500,000	145,000		PRIME+	26,273	6						
7												7						
8	MGMT ALLOCATION										2,389	8						
9	TOTAL Facility Related				\$75,123.97		\$ 11,020,842	\$ 10,387,177			\$ 646,685	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 11,020,842	\$ 10,387,177			\$ 646,685	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2004 report.		\$	130,065	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.)		\$	125,610	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(4,455)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	129,379	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.		\$	124,924	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	91,441	8
	2001	107,989	9
	2002	121,202	10
	2003	123,871	11
	2004	125,610	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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 ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

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

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-29-400-032</u>	<u>NURSING HOME</u>	\$ <u>125,610.34</u>	\$ <u>125,610.34</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>125,610.34</u>	\$ <u>125,610.34</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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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, CNA 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:

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

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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	\$ 296,174	27.5	\$ 296,174	\$	\$ 654,051	4
5										5
6										6
7										7
8	IME ALLOCATION			48,320	1,383		1,383			8
	Improvement Type**									
9	PAINTING		1986	15,680		15			15,680	9
10	ASHALT PAVING		1987	8,180	260	31.5		(260)	8,180	10
11	AVAC UNITS		1988	45,000	1,429	31.5	1,429		36,279	11
12	ROOFING		1989	56,815	1,804	31.5	1,804		29,165	12
13	CUBICLE CURTAIN & TILE		1991	20,473	650	31.5	650		9,398	13
14	PARKING LOTS		1993	19,440	1,296	15	1,296		15,884	14
15	CUBICLE CURTAINS		1993	1,796	46	31.5	46		650	15
16	NURSE STATION		1993	7,800	200	31.5	200		2,822	16
17	ELEVATOR		1994	22,300	572	39	572		6,554	17
18	CUBICLE CURTAINS		1994	843	22	39	22		259	18
19	PARKING LOTS LIGHTS		1995	8,677	578	15	578		6,069	19
20	REPAIR STONE FASCIA		1995	9,750	250	39	250		2,615	20
21	INSULATE SUPPLY/DUCT WORK		1995	7,190	185	39	185		1,880	21
22	TILE		1996	20,387	522	39	522		4,852	22
23	WEATHER-ROOFTOP		1997	6,408	164	39	164		1,319	23
24	METAL DOORS & AIR CONDITION		1998	11,993	308	39	308		2,425	24
25	TWO SHOWERS		1998	2,720	70	39	70		545	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN		1998	9,800	251	39	251		1,872	26
27	CABINERY-ADM., BOOKKEPING, DON		1998	33,000	846	39	846		6,169	27
28	WATER HEATER		1998	4,639	119	39	119		848	28
29	INSTALLED SMOKE AND DUST DETECTORS		1999	4,572	117	39	117		766	29
30	FURNISH AND INSTALL FIRE DAMPERS		1999	25,971	666	39	666		4,246	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE		1999	18,547	476	39	476		2,876	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK		1999	8,640	222	39	222		1,360	32
33	FIRE DAMPERS		2000	8,070	293	20	293		1,624	33
34	FENCE		2000	6,810	477	15	477		2,438	34
35	CUBICLE CURTAINS		2001	14,018	1,615	20	701	(914)	3,505	35
36	ROOF MAINTENANCE & FLASHING REPAIR		2001	6,950	253	27.5	253		1,265	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	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		\$ 510	37
38 IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895	5,172	20	2,245	(2,927)	11,225	38
39 DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		5,240	39
40 ROOF TOP UNITS	2001	12,900	469	27.5	469		2,345	40
41 INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		3,994	41
42 INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	36	27.5	36		36	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)		\$ 8,747,937	\$ 319,353		\$ 315,252	\$ (4,101)	\$ 848,946	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	\$ 366,288	\$ 39,886	\$ 36,196	\$ (3,690)	10 YRS	\$ 165,746	71
72	Current Year Purchases	54,886	12,425	4,046	(8,379)	10 YRS	4,046	72
73	Fully Depreciated Assets	254,576					254,576	73
74	RELATED PARTY SL DEPR		96,116	96,116				74
75	TOTALS	\$ 675,750	\$ 148,427	\$ 136,358	\$ (12,069)		\$ 424,368	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)	\$ 10,473,687	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 467,780	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 451,610	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,170)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,273,314	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: **N/A-RELATED PARTY**

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

If NO, see instructions. YES NO

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

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

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

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ **10,515** 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	FACILITY	2003 FORD E350	\$ 699.00	\$ 8,391	17
18	MAINTENANCE	2004 FORD F150	599.00	7,188	18
19	PAINTERS	2003 CHEV ASTRO VAN	645.00	2,041	19
20					20
21	TOTAL		\$ #####	\$ 17,620	21

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. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
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.)

	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							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			N/A				9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(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	\$ (72,469)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>200,000</u>)	1,573,542		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,868		6
7	Other Prepaid Expenses	90,992		7
8	Accounts Receivable (owners or related parties)	414,326		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,103,259	\$	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	554,831		15
16	Equipment, at Historical Cost	675,750		16
17	Accumulated Depreciation (book methods)	(814,524)		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)	\$ 416,057	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,519,316	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 174,625	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	145,000		29
30	Accrued Salaries Payable	108,726		30
31	Accrued Taxes Payable (excluding real estate taxes)	47,785		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO WAUKEGAN LLC</u>	77,793		36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 553,929	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 553,929	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,965,387	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,519,316	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,758,302	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,758,305	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,107,082	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	(900,000)	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)	\$ 207,082	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)	\$ 1,965,387	24 *

* This must agree with page 17, line 47.

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	\$ 7,676,241	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,676,241	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		24
25	Interest and Other Investment Income***	56	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56	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)	\$ 7,676,297	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,225,721	31
32	Health Care	2,611,770	32
33	General Administration	1,598,854	33
	B. Capital Expense		
34	Ownership	1,017,895	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)*	\$ 6,569,215	40
41	Income before Income Taxes (line 30 minus line 40)**	1,107,082	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,107,082	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: 01/01/2005

Ending: 12/31/2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,911	1,957	\$ 62,222	\$ 31.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,079	28,641	780,439	27.25	3
4	Licensed Practical Nurses	9,856	10,535	261,119	24.79	4
5	CNAs & Orderlies	100,354	107,633	1,199,345	11.14	5
6	CNA Trainees					6
7	Licensed Therapist	4,050	4,505	52,109	11.57	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,419	9,929	95,377	9.61	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,103	27,092	265,197	9.79	15
16	Dishwashers					16
17	Maintenance Workers	10,086	10,301	137,982	13.40	17
18	Housekeepers	20,090	20,926	161,806	7.73	18
19	Laundry	10,507	11,440	99,870	8.73	19
20	Administrator	2,086	2,086	98,800	47.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,869	11,525	119,521	10.37	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	76	76	1,279	16.83	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Quality Assurance</u>	520	520	2,835	5.45	33
34	TOTAL (lines 1 - 33)	231,006	247,166	\$ 3,337,901 *	\$ 13.50	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	monthly fee	\$ 8,790	1-3	35
36	Medical Director	monthly fee	5,200	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	7,928	10-3	39
40	Physical Therapy Consultant	53	2,822	10a-3	40
41	Occupational Therapy Consultant	39	2,062	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	8	424	11-3	44
45	Social Service Consultant	32	1,755	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	monthly fee	3,400	10-3	46
47	<u>DENTAL</u>	monthly fee	4,275	10-3	47
48					48
49	TOTAL (lines 35 - 48)	132	\$ 36,656		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses	N/A	0	10-3	51
52	Certified Nurse Assistants/Aides		0	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	\$ 98,800	Workers' Compensation Insurance	\$ 37,688	IDPH License Fee	\$	
				Unemployment Compensation Insurance	29,678	Advertising: Employee Recruitment	3,042	
				FICA Taxes	245,611	Health Care Worker Background Check	310	
				Employee Health Insurance	63,973	(Indicate # of checks performed <u>22</u>)		
				Employee Meals	9,198	MARKETING/ADV/PROMO	703	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,679	
				EMPLOYEE BENEFITS - OTHER	500	LICENSES & PERMITS	0	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	8,527	
				PENSION/PROFIT SHARING PLANS	30,250	MGMT CO ALLOCATION	1,142	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,679)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(703)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 98,800	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 416,898		\$ 13,021		
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			\$ 371,000				Out-of-State Travel	\$ 1,380
							In-State Travel	
							Seminar Expense	1,955
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 371,000	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 3,335	
C. Professional Services								
Vendor/Payee	Type							
ALPHA DATA	DATA PROCESSING	\$ 4,510						
WESTMONT	DATA PROCESSING	2,400						
LTC SOLUTIONS	DATA PROCESSING	1,320						
MAXXSOURCE	DATA PROCESSING	1,379						
NCS	DATA PROCESSING	2,256						
HEALTH DATE	DATA PROCESSING	2,209						
KBKB	ACCOUNTING	15,900						
HOLLAND & KNIGHT	LEGAL	300						
PERSONNEL PLANNERS	U.C. CONSULTANT	867						
PHILIP ESFORMES, INC	ADMIN CONSULTANT	6,000						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 37,141					

* 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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2002	7 FY2003	8 FY2004	9 FY2005	10 FY2006	11 FY2007	12 FY2008	13 FY2009	14 FY2010
1	PAINT/DECORATING	2003	\$ 7,319	3 YRS	\$	\$ 1,220	\$ 2,440	\$ 2,440	\$ 1,219	\$	\$	\$	\$
2	PAINT/DECORATING	2004	9,626	3 YRS			1,604	3,209	3,209	1,604			
3	PAINT/DECORATING	2005	6,508	3 YRS				1,085	2,169	2,169	1,085		
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20	TOTALS		\$ 23,453		\$	\$ 1,220	\$ 4,044	\$ 6,734	\$ 6,597	\$ 3,773	\$ 1,085	\$	\$

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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 \$8,527
- (3) Did the nursing home make political contributions or payments to a political action 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. \$ 88 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 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, 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. \$ 9,198 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