

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	72,022	1,146	1,017	74,185	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,022	1,146	1,017	74,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.78%

D. How many bed-hold days during this year were paid by the Department?
0 (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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	254,873	16,005	9,607	280,485		280,485	0	280,485		1
2	Food Purchase		199,834		199,834	(9,308)	190,526	(362)	190,164		2
3	Housekeeping	193,019	62,333	0	255,352		255,352	0	255,352		3
4	Laundry	100,404	11,408	1,814	113,626	0	113,626	1,675	115,301		4
5	Heat and Other Utilities			175,935	175,935		175,935	495	176,430		5
6	Maintenance	126,833	10,080	27,508	164,421		164,421	10,712	175,133		6
7	Other (specify):*			16,012	16,012		16,012	121	16,133		7
8	TOTAL General Services	675,129	299,660	230,876	1,205,665	(9,308)	1,196,357	12,641	1,208,998		8
	B. Health Care and Programs										
9	Medical Director	0		8,700	8,700		8,700	0	8,700		9
10	Nursing and Medical Records	2,056,554	130,090	12,880	2,199,524		2,199,524	0	2,199,524		10
10a	Therapy	79,956		4,864	84,820		84,820	0	84,820		10a
11	Activities	102,070	9,837	2,849	114,756		114,756	0	114,756		11
12	Social Services	273,705		3,850	277,555		277,555	0	277,555		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	2,512,285	139,927	33,143	2,685,355	0	2,685,355	0	2,685,355		16
	C. General Administration										
17	Administrative	102,720		400,500	503,220		503,220	(372,397)	130,823		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			32,568	32,568		32,568	12,761	45,329		19
20	Dues, Fees, Subscriptions & Promotions			18,804	18,804		18,804	4,132	22,936		20
21	Clerical & General Office Expenses	150,724	19,645	145,670	316,039		316,039	(82,908)	233,131		21
22	Employee Benefits & Payroll Taxes			454,116	454,116	9,308	463,424	0	463,424		22
23	Inservice Training & Education			2,639	2,639		2,639	0	2,639		23
24	Travel and Seminar			351	351		351	10	361		24
25	Other Admin. Staff Transportation			9,274	9,274		9,274	984	10,258		25
26	Insurance-Prop.Liab.Malpractice			88,032	88,032		88,032	801	88,833		26
27	Other (specify):*			156,175	156,175		156,175	(140,542)	15,633		27
28	TOTAL General Administration	253,444	19,645	1,308,129	1,581,218	9,308	1,590,526	(577,159)	1,013,367		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,440,858	459,232	1,572,148	5,472,238	0	5,472,238	(564,518)	4,907,720		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	8,568
	REPAIRS & MAINTENANCE	1,039
		0
		9,607
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,814
		0
		1,814
5	HEAT & OTHER UTILITIES	
	GAS HEAT	65,834
	ELECTRICITY	55,545
	WATER	53,462
	CABLE TV - LOBBY	1,094
		0
		175,935
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,060
	PAINTING & DECORATING	2,133
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,417
	ELEVATOR MAINTENANCE & REPAIR	7,962
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,090
	FIRE SERVICE	3,846
		0
		0
		0
		0
		27,508
7	OTHER	
	SCAVENGER	10,612
	SECURITY SERVICE	5,400
		0
		0
		16,012
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,700
		8,700

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	156
	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	8,824
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	2,025
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	1,875
		0
		12,880
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	3,587
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,277
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		4,864
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,849
		0
		2,849
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	3,850
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,850
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	400,500
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,887
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	20,681
		0
		32,568
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	3,982
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,020
	LICENSES & PERMITS XIX F	1,757
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	330
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	555
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	120
	PATIENT BACKGROUND CHECKS XIX F	1,040
		18,804
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	399
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	106,100
	PENALTIES / OVERDRAFT CHARGES VI 18	204
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	
	TELEPHONE	18,399
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	20,568
		145,670

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	252,219
	UNEMPLOYMENT COMPENSATION XIX D	30,982
	WORKERS COMPENSATION INSURANC XIX D	72,809
	HOSPITALIZATION INSURANCE XIX D	61,490
	EMPLOYEE BENEFITS - OTHER XIX D	903
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	35,713
	CHICAGO HEAD TAX XIX D	0
		0
		454,116
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,639
		2,639
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	351
		351
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,274
		9,274
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	88,032
		88,032
27	OTHER	
	BAD DEBTS VI 24	156,175
		156,175

GRAND TOTAL COLUMN 3 OTHER

1,572,148

LAKE PARK CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	199,834	PATIENT MEALS	222555
LESS SALES TAX	(362)	ADD EMPLOYEE MEALS	10950
	-----		-----
NET FOOD	199,472	TOTAL MEALS/YEAR	233505
TOTAL PATIENT CENSUS	74,185	NET FOOD	199472
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	233505

TOTAL PATIENT MEALS	222555	COST PER MEAL	0.85
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	9308
	-----		=====
TOTAL EMPLOYEE MEALS	10950		

Facility Name & ID Number

LAKE PARK CENTER

#0027052

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			60,287	60,287		60,287	358,897	419,184			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			63,992	63,992		63,992	618,080	682,072			32
33	Real Estate Taxes				0		0	128,787	128,787			33
34	Rent-Facility & Grounds			874,600	874,600		874,600	(874,600)	0			34
35	Rent-Equipment & Vehicles			29,130	29,130		29,130	5,048	34,178			35
36	Other (specify):* Office Rent			16,380	16,380		16,380	(16,380)	0			36
37	TOTAL Ownership			1,044,389	1,044,389	0	1,044,389	219,832	1,264,221			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			114,975	114,975		114,975	0	114,975			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	114,975	114,975	0	114,975	0	114,975			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,440,858	459,232	2,731,512	6,631,602	0	6,631,602	(344,686)	6,286,916			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:

01/01/2006

Ending:

12/31/2006

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	3,485	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	(362)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(204)	21		18
19	Entertainment	0	20		19
20	Contributions	(555)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(156,175)	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(330)	20		28
29	Other-Attach Schedule SEE PAGE 5-A	(15,749)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (169,890)		\$ 0	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(174,796)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (174,796)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (344,686)		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: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 4,819	6	1
2	STAFF DEVELOPMENT	(20,568)	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	(15,749)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(362)	0	0	0	0	0	0	0	0	0	0	(362)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,675	0	0	0	0	0	0	0	0	1,675	4
5	Heat and Other Utilities	0	495	0	0	0	0	0	0	0	0	0	495	5
6	Maintenance	4,819	902	2,229	2,762	0	0	0	0	0	0	0	10,712	6
7	Other (specify):*	0	50	71	0	0	0	0	0	0	0	0	121	7
8	TOTAL General Services	4,457	1,447	3,975	2,762	0	12,641	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	10,464	(382,861)	0	0	0	0	0	0	0	(372,397)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	75	11,109	1,577	0	0	0	0	0	0	0	12,761	19
20	Fees, Subscriptions & Promotions	(885)	0	5,017	0	0	0	0	0	0	0	0	4,132	20
21	Clerical & General Office Expenses	(20,772)	92	(78,228)	16,000	0	0	0	0	0	0	0	(82,908)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10	0	0	0	0	0	0	0	0	10	24
25	Other Admin. Staff Transportation	0	0	549	435	0	0	0	0	0	0	0	984	25
26	Insurance-Prop.Liab.Malpractice	0	209	340	252	0	0	0	0	0	0	0	801	26
27	Other (specify):*	(156,175)	0	7,941	7,692	0	0	0	0	0	0	0	(140,542)	27
28	TOTAL General Administration	(177,832)	376	(42,798)	(356,905)	0	(577,159)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(173,375)	1,823	(38,823)	(354,143)	0	(564,518)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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	3,485	1,448	334	353,630	0	0	0	0	0	0	0	358,897	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,912	0	615,168	0	0	0	0	0	0	0	618,080	32
33	Real Estate Taxes	0	2,088	0	126,699	0	0	0	0	0	0	0	128,787	33
34	Rent-Facility & Grounds	0	0	0	(874,600)	0	0	0	0	0	0	0	(874,600)	34
35	Rent-Equipment & Vehicles	0	479	3,945	624	0	0	0	0	0	0	0	5,048	35
36	Other (specify):*	0	(16,380)	0	0	0	0	0	0	0	0	0	(16,380)	36
37	TOTAL Ownership	3,485	(9,453)	4,279	221,521	0	219,832	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)	(169,890)	(7,630)	(34,544)	(132,622)	0	(344,686)	45						

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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
				IME REALTY CORP.	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		WAUKEGAN		
				PROPERTIES, 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		"		495	495	2
3	V	6 REPAIRS/MAINT		"		902	902	3
4	V	19 PROFESSIONAL FEES		"		75	75	4
5	V	21 OFFICE EXPENSE		"		92	92	5
6	V	26 INSURANCE		"		209	209	6
7	V	30 DEPRECIATION (SL)		"		1,448	1,448	7
8	V	32 INTEREST		"		2,912	2,912	8
9	V	33 RE TAXES		"		2,088	2,088	9
10	V	35 STORAGE FEES		"		479	479	10
11	V	7 ALARM SERVICE		"		50	50	11
12	V							12
13	V							13
14	Total		\$ 16,380			\$ 8,750	\$ * (7,630)	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	\$ 106,100	EKS MANAGEMENT CO.		\$	\$ (106,100)
16	V	6 PAINTERS SALARIES		" " "		2,229	2,229
17	V	7 SCAVENGER		" " "		71	71
18	V	17 CFO SALARY		" " "		10,464	10,464
19	V	19 PROFESSIONAL FEES		" " "		11,109	11,109
20	V	20 WANT ADS/BACKGR CKS		" " "		5,017	5,017
21	V	21 TOTAL OFFICE		" " "		27,872	27,872
22	V	24 IN-STATE TRAVEL		" " "		10	10
23	V	25 TRANSPORTATION		" " "		549	549
24	V	26 INSURANCE		" " "		340	340
25	V	27 EMPLOYEE BENEFITS		" " "		7,941	7,941
26	V	30 DEPRECIATION (SL)		" " "		334	334
27	V	35 EQUIPMENT RENT		" " "		3,945	3,945
28	V	4 HOUSEKEEPING SALARIES		" " "		1,675	1,675
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 106,100			\$ 71,556	\$ * (34,544)

* 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	\$ 400,500	EMI ENTERPRISES INC.		\$	\$ (400,500)
16	V	17 OFFICERS SALARY		" " "		17,639	17,639
17	V	19 ACCOUNTING FEES		" " "		1,577	1,577
18	V	21 TOTAL OFFICE		" " "		16,000	16,000
19	V	25 TRANSPORTATION		" " "		435	435
20	V	26 INSURANCE		" " "		252	252
21	V	27 EMPLOYEE BENEFITS		" " "		7,692	7,692
22	V	35 AUTO LEASE		" " "		624	624
23	V	6 DRIVERS SALARY		" " "		2,762	2,762
24	V						
25	V						
26	V						
27	V	34 RENT	874,600	WAUKEGAN TERRACE PROPERTIES LLC			(874,600)
28	V	33 REAL ESTATE TAX		" " " "		126,699	126,699
29	V	30 DEPRECIATION (SL)		" " " "		353,630	353,630
30	V	32 INTEREST		" " " "		564,864	564,864
31	V	32 MORTGAGE INSURANCE		" " " "		50,304	50,304
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,275,100			\$ 1,142,478	\$ * (132,622)

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

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	ADMINISTRATIVE			SEE			\$	1
2	AVRUM WEINFELD	CFO	CFO			ATTACHED				2
3	PHILLIP ESFORMES	CONSULTANT	ADMINISTRATIVE			SCHEDULE				3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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	863,827	14	\$ 25,953	\$ 74,185	\$ 2,229	1
2	7	SCAVENGER	PATIENT DAYS	863,827	14	825	74,185	71	2
3	17	CFO SALARY	PATIENT DAYS	863,827	14	121,844	74,185	10,464	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	863,827	14	129,352	74,185	11,109	4
5	20	WANT ADS / BACKGR CKS	PATIENT DAYS	863,827	14	58,423	74,185	5,017	5
6	21	TOTAL OFFICE	PATIENT DAYS	863,827	14	324,544	74,185	27,872	6
7	24	IN-STATE TRAVEL	PATIENT DAYS	863,827	14	112	74,185	10	7
8	25	TRANSPORTATION	PATIENT DAYS	863,827	14	6,388	74,185	549	8
9	26	INSURANCE	PATIENT DAYS	863,827	14	3,958	74,185	340	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	863,827	14	92,462	74,185	7,941	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	863,827	14	3,880	74,185	334	11
12	35	EQUIPMENT RENT	PATIENT DAYS	863,827	14	45,937	74,185	3,945	12
13	4	HOUSEKEEPING SALARIES	PATIENT DAYS	863,827	14	19,500	74,185	1,675	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					\$ 833,178	\$ 496,665	\$ 71,556	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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	344,402	15	\$ 10,404	\$ 16,380	\$ 495	1
2	6	REPAIRS/MAINT	PATIENT DAYS	344,402	15	18,957	16,380	902	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	344,402	15	1,575	16,380	75	3
4	21	OFFICE EXPENSE	PATIENT DAYS	344,402	15	1,942	16,380	92	4
5	26	INSURANCE	PATIENT DAYS	344,402	15	4,387	16,380	209	5
6	30	DEPRECIATION (SL)	PATIENT DAYS	344,402	15	30,446	16,380	1,448	6
7	32	INTEREST	PATIENT DAYS	344,402	15	61,229	16,380	2,912	7
8	33	RE TAX	PATIENT DAYS	344,402	15	43,904	16,380	2,088	8
9	35	STORAGE FEES	PATIENT DAYS	344,402	15	10,073	16,380	479	9
10	7	ALARM SERVICE	PATIENT DAYS	344,402	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					\$ 183,973	\$	\$ 8,750	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 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

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	17	OFFICERS SALARY	PATIENT DAYS	778,042	14	\$ 185,000	\$ 185,000	74,185	\$ 17,639	1
2	19	ACCOUNTING FEES	PATIENT DAYS	778,042	14	16,537	74,185		1,577	2
3	21	TOTAL OFFICE	PATIENT DAYS	778,042	14	167,811	132,028	74,185	16,000	3
4	25	TRANSPORTATION	PATIENT DAYS	778,042	14	4,565	74,185		435	4
5	35	INSURANCE	PATIENT DAYS	778,042	14	2,648	74,185		252	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	778,042	14	80,669	74,185		7,692	6
7	35	AUTO LEASE	PATIENT DAYS	778,042	14	6,544	74,185		624	7
8	6	DRIVERS SALARY	PATIENT DAYS	778,042	14	28,965	28,965	74,185	2,762	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					\$ 492,739	\$ 345,993		\$ 46,981	25

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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		10,324,600	9,936,358	04/39	5.1400	558,893	2						
3	LOAN COST		X	LOAN COSTS	W/O OVER LOAN		196,242	179,821			5,971	3						
4	MIP INSURANCE		X	INSURANCE							50,304	4						
5												5						
Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND		500,000	1,445,000		PRIME+	63,992	6						
7												7						
8	MGMT ALLOCATION										2,912	8						
9	TOTAL Facility Related				\$75,123.97		\$ 11,020,842	\$ 11,561,179			\$ 682,072	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 11,020,842	\$ 11,561,179			\$ 682,072	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 50,304 Line # 32

* 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 2005 report.		\$	129,379	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.)		\$	127,086	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,293)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	128,992	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.		\$	126,699	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	107,989	8
	2002	121,202	9
	2003	123,871	10
	2004	125,610	11
	2005	127,086	12

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 2005 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>127,085.55</u>	\$ <u>127,085.55</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>127,085.55</u>	\$ <u>127,085.55</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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).

N/A

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

1. Total Amount Incurred: _____ 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>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 1,050,000	3

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	210	2003	1967	\$ 8,144,786	\$ 296,174	27.5	\$ 296,174	\$	\$ 950,225	4
5										5
6										6
7										7
8	IME ALLOCATION			48,320	1,391		1,391			8
	Improvement Type**									
9	PAINTING		1986	15,680		15	0		15,680	9
10	ASHALT PAVING		1987	8,180	260	31.5	0	(260)	8,180	10
11	AVAC UNITS		1988	45,000	1,429	31.5	1,429		37,708	11
12	ROOFING		1989	56,815	1,804	31.5	1,804		30,969	12
13	CUBICLE CURTAIN & TILE		1991	20,473	650	31.5	650		10,048	13
14	PARKING LOTS		1993	19,440	1,296	15	1,296		17,180	14
15	CUBICLE CURTAINS		1993	1,796	46	31.5	46		696	15
16	NURSE STATION		1993	7,800	200	31.5	200		3,022	16
17	ELEVATOR		1994	22,300	572	39	572		7,126	17
18	CUBICLE CURTAINS		1994	843	22	39	22		281	18
19	PARKING LOTS LIGHTS		1995	8,677	578	15	578		6,647	19
20	REPAIR STONE FASCIA		1995	9,750	250	39	250		2,865	20
21	INSULATE SUPPLY/DUCT WORK		1995	7,190	185	39	185		2,065	21
22	TILE		1996	20,387	522	39	522		5,374	22
23	WEATHER-ROOFTOP		1997	6,408	164	39	164		1,483	23
24	METAL DOORS & AIR CONDITION		1998	11,993	308	39	308		2,733	24
25	TWO SHOWERS		1998	2,720	70	39	70		615	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN		1998	9,800	251	39	251		2,123	26
27	CABINERY-ADM., BOOKKEPING, DON		1998	33,000	846	39	846		7,015	27
28	WATER HEATER		1998	4,639	119	39	119		967	28
29	INSTALLED SMOKE AND DUST DETECTORS		1999	4,572	117	39	117		883	29
30	FURNISH AND INSTALL FIRE DAMPERS		1999	25,971	666	39	666		4,912	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE		1999	18,547	476	39	476		3,352	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK		1999	8,640	222	39	222		1,582	32
33	FIRE DAMPERS		2000	8,070	293	20	293		1,917	33
34	FENCE		2000	6,810	477	15	477		2,915	34
35	CUBICLE CURTAINS		2001	14,018	807	20	701	(106)	4,206	35
36	ROOF MAINTENANCE & FLASHING REPAIR		2001	6,950	253	27.5	253		1,518	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		\$ 612	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895	2,586	20	2,245	(341)	13,470	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		6,288	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		2,814	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		5,272	41
42	INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		902	42
43	INSTALL STEEL ROLLING DOOR	2006	2,878	92	27.5	92		92	43
44	REPLACE HOT WATER HEATER	2006	8,476	193	27.5	193		193	44
45	INSTALL SWING GATES WITH POSTS	2006	1,825	51	15	122	71	122	45
46	SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	248	15	992	744	992	46
47	INSTALL DOORS	2006	171,211	259	27.5	259		259	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)		\$ 8,947,202	\$ 317,640		\$ 317,748	\$ 108	\$ 1,165,303	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	\$ 412,486	\$ 39,601	\$ 43,436	\$ 3,835	10 YRS	\$ 204,540	71
72	Current Year Purchases	3,054	611	153	(458)	10 YRS	153	72
73	Fully Depreciated Assets	263,264			0		263,264	73
74	RELATED PARTY SL DEPR		57,847	57,847	0			74
75	TOTALS	\$ 678,804	\$ 98,059	\$ 101,436	\$ 3,377		\$ 467,957	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 10,676,006	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 415,699	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 419,184	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,485	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,633,260	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: \$ 10,419 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	FACILTY	2003 FORD E350	\$ 699.25	\$ 5,095	17
18	FACILTY	2006 FORD E350	690.00	3,500	18
19	MAINTENANCE	2004 FORD F150	599.00	7,323	19
20	PAINTERS	2003 CHEV ASTRO VAN	645.00	2,793	20
21	TOTAL		\$ #####	\$ 18,711	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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. <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 CNA _____</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 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	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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			N/A			#VALUE!	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! 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: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ (115,831)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>200,000</u>)	2,750,429		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,826		6
7	Other Prepaid Expenses	162,080		7
8	Accounts Receivable (owners or related parties)	422,543		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,323,047	\$ 0	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	754,096		15
16	Equipment, at Historical Cost	678,803		16
17	Accumulated Depreciation (book methods)	(874,811)		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): <u>Construction Escrow</u>	8,500		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 566,588	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,889,635	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 162,464	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,456,099		29
30	Accrued Salaries Payable	110,492		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,335		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	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,777,390	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,777,390	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,112,245	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,889,635	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,965,387	1
2	Restatements (describe):		2
3	ROUNDING	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,965,383	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,096,862	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	(950,000)	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)	\$ 146,862	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,112,245	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	\$ 7,748,638	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,748,638	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)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,748,638	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,205,665	31
32	Health Care	2,685,355	32
33	General Administration	1,581,218	33
	B. Capital Expense		
34	Ownership	1,044,389	34
	C. Ancillary Expense		
35	Special Cost Centers	0	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)*	\$ 6,631,602	40
41	Income before Income Taxes (line 30 minus line 40)**	1,117,036	41
42	Income Taxes	(20,174)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,096,862	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:

01/01/2006

Ending:

12/31/2006

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	2,083	2,129	\$ 70,241	\$ 32.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,239	27,726	767,184	27.67	3
4	Licensed Practical Nurses	11,184	12,037	305,213	25.36	4
5	CNAs & Orderlies	74,232	80,350	902,576	11.23	5
6	CNA Trainees					6
7	Licensed Therapist	5,826	6,550	79,956	12.21	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,783	10,399	102,070	9.82	10
11	Social Service Workers	21,176	22,334	273,705	12.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,695	24,451	254,873	10.42	15
16	Dishwashers					16
17	Maintenance Workers	8,981	9,087	126,833	13.96	17
18	Housekeepers	22,098	23,490	193,019	8.22	18
19	Laundry	10,007	11,200	100,404	8.96	19
20	Administrator	2,080	2,080	102,720	49.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,308	13,110	150,724	11.50	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>	2,080	2,080	11,340	5.45	33
34	TOTAL (lines 1 - 33)	229,772	247,023	\$ 3,440,858 *	\$ 13.93	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	\$ 8,568	1-3	35
36	Medical Director	Monthly Fee	8,700	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fee	8,824	10-3	39
40	Physical Therapy Consultant	63	3,587	10a-3	40
41	Occupational Therapy Consultant	22	1,277	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	52	2,849	11-3	44
45	Social Service Consultant	70	3,850	12-3	45
46	Other(specify) <u>Psychiatric</u>	Monthly Fee	2,025	10-3	46
47	<u>Dental</u>	Monthly Fee	1,875	10-3	47
48					48
49	TOTAL (lines 35 - 48)	207	\$ 41,555		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	Certified Nurse Assistants/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	
BRYAN LIVINGS	ADMINISTRATOR	0.00%	\$ 102,720	Workers' Compensation Insurance	\$ 72,809	IDPH License Fee	\$	
				Unemployment Compensation Insurance	30,982	Advertising: Employee Recruitment	3,982	
				FICA Taxes	252,219	Health Care Worker Background Check	120	
				Employee Health Insurance	61,490	(Indicate # of checks performed 12)		
				Employee Meals	9,308	Patient Background Checks	33 1,040	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	555	
				EMPLOYEE BENEFITS - OTHER	903	MARKETING/ADV/PROMO	330	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	12,777	
				PENSION/PROFIT SHARING PLANS	35,713	MGMT CO ALLOC	5,571	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(555)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(0)	
						Yellow page advertising	(330)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,720	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 463,424		\$ 23,490		
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 MANAGEMENT FEES			\$ 397,000			\$	Out-of-State Travel	\$
P. ESFORMES MANAGEMENT FEES			3,500					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 400,500					351
							MGMT CO ALLOC	11
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount					
ALPHA DATA	DATA PROCESSING		\$ 4,621				0	
WESTMONT	DATA PROCESSING		2,400					
LTC SOLUTIONS	DATA PROCESSING		1,320					
MAXXSOURCE	DATA PROCESSING		1,265					
HDSI	DATA PROCESSING		2,282					
KBKB	ACCOUNTING		15,900					
SACHNOFF & WEAVER	LEGAL FEES		1,000					
FREDERICK FRANKEL	LEGAL FEES		800					
MONAHAM & COHEN	LEGAL FEES		1,735					
L. SCHWARTZ	LEGAL FEES		480					
PERSONNEL PLANNERS	U.C. CONSULTANT		765					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 32,568	TOTAL		\$	Entertainment Expense ()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 362	

* 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								
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
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															
4	PAINT/DECORATING	2006	2,133	3 YRS				355	711	711	356														
5																									
6																									
7																									
8																									
9																									
10																									
11																									
12																									
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16																									
17																									
18																									
19																									
20	TOTALS		\$ 25,586		\$ 1,220	\$ 4,044	\$ 6,734	\$ 6,952	\$ 4,484	\$ 1,796	\$ 356	\$	\$												

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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 \$3670
- (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. \$ 22 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. \$ 9,308 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