

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			1,095	1,095	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	72,147	1,080		73,227	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,147	1,080	1,095	74,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.96%

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

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **LAKE PARK CENTER** # **0027052** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	268,842	14,586	9,516	292,944		292,944		292,944		1
2	Food Purchase		219,367		219,367	(10,184)	209,183	(1,198)	207,985		2
3	Housekeeping	178,759	44,846		223,605		223,605		223,605		3
4	Laundry	80,492	10,681	1,196	92,369		92,369	1,689	94,058		4
5	Heat and Other Utilities			192,478	192,478		192,478	452	192,930		5
6	Maintenance	137,569	12,934	33,312	183,815		183,815	10,872	194,687		6
7	Other (specify):*			18,409	18,409		18,409	94	18,503		7
8	TOTAL General Services	665,662	302,414	254,911	1,222,987	(10,184)	1,212,803	11,909	1,224,712		8
	B. Health Care and Programs										
9	Medical Director			16,500	16,500		16,500		16,500		9
10	Nursing and Medical Records	2,060,926	110,180	15,248	2,186,354		2,186,354	1,641	2,187,995		10
10a	Therapy	53,802		2,764	56,566		56,566		56,566		10a
11	Activities	105,992	8,988	344	115,324		115,324		115,324		11
12	Social Services	287,281		3,245	290,526		290,526		290,526		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,508,001	119,168	38,101	2,665,270		2,665,270	1,641	2,666,911		16
	C. General Administration										
17	Administrative	102,720		497,000	599,720		599,720	(470,160)	129,560		17
18	Directors Fees										18
19	Professional Services			31,927	31,927		31,927	19,823	51,750		19
20	Dues, Fees, Subscriptions & Promotions			21,727	21,727		21,727	340	22,067		20
21	Clerical & General Office Expenses	199,940	15,461	156,049	371,450		371,450	(63,426)	308,024		21
22	Employee Benefits & Payroll Taxes			482,786	482,786	10,184	492,970		492,970		22
23	Inservice Training & Education							57	57		23
24	Travel and Seminar			2,860	2,860		2,860		2,860		24
25	Other Admin. Staff Transportation			7,864	7,864		7,864	1,211	9,075		25
26	Insurance-Prop.Liab.Malpractice			92,314	92,314		92,314	14,881	107,195		26
27	Other (specify):*							14,106	14,106		27
28	TOTAL General Administration	302,660	15,461	1,292,527	1,610,648	10,184	1,620,832	(483,168)	1,137,664		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,476,323	437,043	1,585,539	5,498,905		5,498,905	(469,618)	5,029,287		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	948
		0
		9,516
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,196
		0
		1,196
5	HEAT & OTHER UTILITIES	
	GAS HEAT	69,385
	ELECTRICITY	71,902
	WATER	51,043
	CABLE TV - LOBBY	148
		0
		192,478
6	MAINTENANCE	
	GROUNDS MAINTENANCE	11,315
	PAINTING & DECORATING	284
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,100
	ELEVATOR MAINTENANCE & REPAIR	6,738
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,608
	FIRE SERVICE	6,267
		0
		0
		0
		0
		33,312
7	OTHER	
	SCAVENGER	13,009
	SECURITY SERVICE	5,400
		0
		0
		18,409
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	16,500
		16,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	874
	PURCHASED SERVICES	144
	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	6,655
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	3,075
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	4,500
		0
		15,248
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	2,434
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	330
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,764
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	344
		0
		344
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	3,245
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,245
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	497,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,153
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	20,774
		0
		31,927
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,836
	EMPLOYEE WANT ADS XIX F	3,208
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	12,600
	LICENSES & PERMITS XIX F	2,808
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	275
	PATIENT BACKGROUND CHECKS XIX F	0
		21,727
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	43
	EQUIPMENT REPAIR & MAINTENANCE	56
	OUTSIDE CLERICAL SERVICES	106,600
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	14,763
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	34,587
		156,049

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	254,352
	UNEMPLOYMENT COMPENSATION XIX D	28,649
	WORKERS COMPENSATION INSURANC XIX D	69,431
	HOSPITALIZATION INSURANCE XIX D	97,841
	EMPLOYEE BENEFITS - OTHER XIX D	675
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	31,838
	CHICAGO HEAD TAX XIX D	0
		0
		482,786
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,860
	TRAVEL XIX G	0
		2,860
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,864
		7,864
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	92,314
		92,314
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,585,539

**LAKE PARK CENTER
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	219,367
LESS SALES TAX	<u>(1,198)</u>
NET FOOD	218,169

TOTAL PATIENT CENSUS	74,322
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	222,966

ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	10,950

PATIENT MEALS	222,966
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	233,916

NET FOOD	218,169
DIVIDE TOTAL MEALS/YEAR	<u>233,916</u>

COST PER MEAL	0.93
TIME EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	10,184

=====

Facility Name & ID Number

LAKE PARK CENTER

#0027052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			41,497	41,497		41,497	361,054	402,551			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,421	41,421		41,421	599,316	640,737			32
33	Real Estate Taxes							137,058	137,058			33
34	Rent-Facility & Grounds			937,200	937,200		937,200	(937,200)				34
35	Rent-Equipment & Vehicles			28,017	28,017		28,017	4,926	32,943			35
36	Other (specify):* Office Rent			16,380	16,380		16,380	(16,380)				36
37	TOTAL Ownership			1,064,515	1,064,515		1,064,515	148,774	1,213,289			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)	3,476,323	437,043	2,765,029	6,678,395		6,678,395	(320,844)	6,357,551			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:

01/01/2007

Ending:

12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24,412	30		9
10	Interest and Other Investment Income	(11,990)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,198)	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		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,953)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(2,836)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	4,484			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 9,919		\$	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)	(330,763)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (330,763)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (320,844)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 4,484	6 1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	4,484	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,198)	0	0	0	0	0	0	0	0	0	0	(1,198)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	1,689	0	0	0	0	0	0	0	0	1,689	4
5	Heat and Other Utilities	0	452	0	0	0	0	0	0	0	0	0	452	5
6	Maintenance	4,484	1,734	2,248	2,406	0	0	0	0	0	0	0	10,872	6
7	Other (specify):*	0	50	44	0	0	0	0	0	0	0	0	94	7
8	TOTAL General Services	3,286	2,236	3,981	2,406	0	11,909	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	1,641	0	0	0	0	0	0	0	1,641	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	1,641	0	1,641	16						
	C. General Administration													
17	Administrative	0	0	10,789	(480,949)	0	0	0	0	0	0	0	(470,160)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,953)	83	10,460	12,233	0	0	0	0	0	0	0	19,823	19
20	Fees, Subscriptions & Promotions	(2,836)	0	3,176	0	0	0	0	0	0	0	0	340	20
21	Clerical & General Office Expenses	0	73	(76,100)	12,601	0	0	0	0	0	0	0	(63,426)	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	57	0	0	0	0	0	0	0	0	57	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	681	530	0	0	0	0	0	0	0	1,211	25
26	Insurance-Prop.Liab.Malpractice	0	101	589	14,191	0	0	0	0	0	0	0	14,881	26
27	Other (specify):*	0	0	6,080	8,026	0	0	0	0	0	0	0	14,106	27
28	TOTAL General Administration	(5,789)	257	(44,268)	(433,368)	0	(483,168)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,503)	2,493	(40,287)	(429,321)	0	(469,618)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	24,412	1,451	355	334,836	0	0	0	0	0	0	0	361,054	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,990)	2,730	0	608,576	0	0	0	0	0	0	0	599,316	32
33	Real Estate Taxes	0	2,033	0	135,025	0	0	0	0	0	0	0	137,058	33
34	Rent-Facility & Grounds	0	0	0	(937,200)	0	0	0	0	0	0	0	(937,200)	34
35	Rent-Equipment & Vehicles	0	483	3,241	1,202	0	0	0	0	0	0	0	4,926	35
36	Other (specify):*	0	(16,380)	0	0	0	0	0	0	0	0	0	(16,380)	36
37	TOTAL Ownership	12,422	(9,683)	3,596	142,439	0	148,774	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)	9,919	(7,190)	(36,691)	(286,882)	0	(320,844)	45						

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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		
				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		" " "		452	452	2
3	V	6 REPAIRS/MAINT		" " "		1,195	1,195	3
4	V	19 PROFESSIONAL FEES		" " "		83	83	4
5	V	21 OFFICE EXPENSE		" " "		73	73	5
6	V	26 INSURANCE		" " "		101	101	6
7	V	30 DEPRECIATION (SL)		" " "		1,451	1,451	7
8	V	32 INTEREST		" " "		2,730	2,730	8
9	V	33 RE TAXES		" " "		2,033	2,033	9
10	V	35 STORAGE FEES		" " "		483	483	10
11	V	7 ALARM SERVICE		" " "		50	50	11
12	V	6 PAINTERS FEES		" " "		539	539	12
13	V							13
14	Total		\$ 16,380			\$ 9,190	\$ * (7,190)	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	\$ 106,600	EKS MANAGEMENT CO.		\$	\$ (106,600)
16	V	6 PAINTERS SALARIES		" " "		2,248	2,248
17	V	7 SCAVENGER		" " "		44	44
18	V	17 CFO SALARY		" " "		10,789	10,789
19	V	19 PROFESSIONAL FEES		" " "		10,460	10,460
20	V	20 WANT ADS/BACKGR CKS		" " "		3,176	3,176
21	V	21 TOTAL OFFICE		" " "		30,500	30,500
22	V	23 SEMINAR		" " "		57	57
23	V	25 TRANSPORTATION		" " "		681	681
24	V	26 INSURANCE		" " "		589	589
25	V	27 EMPLOYEE BENEFITS		" " "		6,080	6,080
26	V	30 DEPRECIATION (SL)		" " "		355	355
27	V	35 EQUIPMENT RENT		" " "		3,241	3,241
28	V	4 HOUSEKEEPING SALARIES		" " "		1,689	1,689
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 106,600			\$ 69,909	\$ * (36,691)

* 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	\$ 497,000	EMI ENTERPRISES INC.		\$	\$ (497,000)
16	V	17 OFFICERS SALARY		" " "		16,051	16,051
17	V	19 ACCOUNTING FEES		" " "		733	733
18	V	21 TOTAL OFFICE		" " "		12,601	12,601
19	V	25 TRANSPORTATION		" " "		530	530
20	V	26 INSURANCE		" " "		741	741
21	V	27 EMPLOYEE BENEFITS		" " "		8,026	8,026
22	V	35 AUTO LEASE		" " "		1,202	1,202
23	V	6 DRIVERS SALARY		" " "		2,406	2,406
24	V	10 NURSING CONSULTANTS		" " "		1,641	1,641
25	V	30 DEPRECIATION (SL)		" " "		299	299
26	V						
27	V						
28	V	34 RENT	937,200	WAUKEGAN TERRACE PROPERTIES LLC			(937,200)
29	V	33 REAL ESTATE TAX		" " " "		135,025	135,025
30	V	30 DEPRECIATION (SL)		" " " "		334,537	334,537
31	V	32 INTEREST		" " " "		558,687	558,687
32	V	32 MORTGAGE INSURANCE		" " " "		49,889	49,889
33	V	26 INSURANCE		" " " "		13,450	13,450
34	V	19 PROFESSIONAL FEES		" " " "		11,500	11,500
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,434,200			\$ 1,147,318	\$ * (286,882)

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

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 16,051	17-7	1
2	AVRUM WEINFELD	CFO	CFO	1.43	SCHEDULE			SALARY	10,789	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,840		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: 01/01/2007

Ending: 2/31/2007

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	857,979	14	\$ 25,953	\$ 74,322	\$ 2,248	1
2	7	SCAVENGER	PATIENT DAYS	857,979	14	512	74,322	44	2
3	17	CFO SALARY	PATIENT DAYS	857,979	14	124,552	74,322	10,789	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	857,979	14	120,756	74,322	10,460	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	857,979	14	36,665	74,322	3,176	5
6	21	TOTAL OFFICE	PATIENT DAYS	857,979	14	352,089	74,322	30,500	6
7	23	SEMINAR	PATIENT DAYS	857,979	14	659	74,322	57	7
8	25	TRANSPORTATION	PATIENT DAYS	857,979	14	7,865	74,322	681	8
9	26	INSURANCE	PATIENT DAYS	857,979	14	6,798	74,322	589	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	857,979	14	70,186	74,322	6,080	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	857,979	14	4,096	74,322	355	11
12	35	EQUIPMENT RENT	PATIENT DAYS	857,979	14	37,419	74,322	3,241	12
13	4	HOUSEKEEPING SALARIES	PATIENT DAYS	857,979	14	19,500	74,322	1,689	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					\$ 807,050	\$ 517,263	\$ 69,909	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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	187,059	14	\$ 5,162	\$ 16,380	\$ 452	1
2	6	REPAIRS/MAINT	PATIENT DAYS	187,059	14	13,651	16,380	1,195	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	187,059	14	952	16,380	83	3
4	21	OFFICE EXPENSE	PATIENT DAYS	187,059	14	831	16,380	73	4
5	26	INSURANCE	PATIENT DAYS	187,059	14	1,150	16,380	101	5
6	30	DEPRECIATION (SL)	PATIENT DAYS	187,059	14	16,570	16,380	1,451	6
7	32	INTEREST	PATIENT DAYS	187,059	14	31,178	16,380	2,730	7
8	33	RE TAXES	PATIENT DAYS	187,059	14	23,213	16,380	2,033	8
9	35	STORAGE FEES	PATIENT DAYS	187,059	14	5,519	16,380	483	9
10	7	ALARM SERVICE	PATIENT DAYS	187,059	14	575	16,380	50	10
11	6	PAINTERS FEES	PATIENT DAYS	187,059	14	6,152	16,380	539	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					\$ 104,953	\$	\$ 9,190	25

Facility Name & ID Number LAKE PARK CENTER

0027052 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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	342,637	4	\$ 74,000	\$ 74,000	74,322	\$ 16,051	1
2	19	ACCOUNTING FEES	PATIENT DAYS	342,637	4	3,380	74,322	74,322	733	2
3	21	TOTAL OFFICE	PATIENT DAYS	342,637	4	58,095	43,765	74,322	12,601	3
4	25	TRANSPORTATION	PATIENT DAYS	342,637	4	2,444	74,322	74,322	530	4
5	35	INSURANCE	PATIENT DAYS	342,637	4	3,417	74,322	74,322	741	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	342,637	4	37,000	74,322	74,322	8,026	6
7	35	AUTO LEASE	PATIENT DAYS	342,637	4	5,543	74,322	74,322	1,202	7
8	6	DRIVERS SALARY	PATIENT DAYS	342,637	4	11,091	11,091	74,322	2,406	8
9	10	NURSING CONSULTANTS	PATIENT DAYS	342,637	4	7,567	74,322	74,322	1,641	9
10	30	DEPRECIATION (SL)	PATIENT DAYS	342,637	4	1,380	74,322	74,322	299	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					\$ 203,917	\$ 128,856		\$ 44,230	25

Facility Name & ID Number

LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$75,439.10	04/04	10,324,600	9,941,855	04/39	5.1400	552,716	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		192,242	173,850			5,971	3						
4	MIP INSURANCE		X								49,889	4						
5												5						
Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND		500,000	768,000		PRIME+	41,421	6						
7												7						
8	IME REALTY ALLOCATION										2,730	8						
9	TOTAL Facility Related				\$75,439.10		\$ 11,016,842	\$ 10,883,705			\$ 652,727	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 11,016,842	\$ 10,883,705			\$ 652,727	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 49,889 Line # 32-7

* 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 2006 report.		\$	128,992	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.)		\$	130,420	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,428	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	133,597	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.		\$	135,025	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	121,202	8	
	2003	123,871	9	
	2004	125,610	10	
	2005	127,086	11	
	2006	130,420	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>130,420.29</u>	\$ <u>130,420.29</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>130,420.29</u>	\$ <u>130,420.29</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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			<u>\$ 1,050,000</u>	<u>3</u>

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 1,246,399	4
5										5
6										6
7										7
8	IME ALLOCATION				1,394		1,394			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		39,137	11
12	ROOFING		1989	56,815	1,804	31.5	1,804		32,773	12
13	CUBICLE CURTAIN & TILE		1991	20,473	650	31.5	650		10,698	13
14	PARKING LOTS		1993	19,440	1,296	15	1,296		18,476	14
15	CUBICLE CURTAINS		1993	1,796	46	31.5	46		742	15
16	NURSE STATION		1993	7,800	200	31.5	200		3,222	16
17	ELEVATOR		1994	22,300	572	39	572		7,698	17
18	CUBICLE CURTAINS		1994	843	22	39	22		303	18
19	PARKING LOTS LIGHTS		1995	8,677	578	15	578		7,225	19
20	REPAIR STONE FASCIA		1995	9,750	250	39	250		3,115	20
21	INSULATE SUPPLY/DUCT WORK		1995	7,190	185	39	185		2,250	21
22	TILE		1996	20,387	522	39	522		5,896	22
23	WEATHER-ROOFTOP		1997	6,408	164	39	164		1,647	23
24	METAL DOORS & AIR CONDITION		1998	11,993	308	39	308		3,041	24
25	TWO SHOWERS		1998	2,720	70	39	70		685	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN		1998	9,800	251	39	251		2,374	26
27	CABINERY-ADM., BOOKKEPING, DON		1998	33,000	846	39	846		7,861	27
28	WATER HEATER		1998	4,639	119	39	119		1,086	28
29	INSTALLED SMOKE AND DUST DETECTORS		1999	4,572	117	39	117		1,000	29
30	FURNISH AND INSTALL FIRE DAMPERS		1999	25,971	666	39	666		5,578	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE		1999	18,547	476	39	476		3,828	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK		1999	8,640	222	39	222		1,804	32
33	FIRE DAMPERS		2000	8,070	293	20	293		2,210	33
34	FENCE		2000	6,810	477	15	477		3,392	34
35	CUBICLE CURTAINS		2001	14,018		20	701	701	4,907	35
36	ROOF MAINTENANCE & FLASHING REPAIR		2001	6,950	253	27.5	253		1,771	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 714	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895		20	2,245	2,245	15,715	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		7,336	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		3,283	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		6,550	41
42	INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		1,768	42
43	INSTALL STEEL ROLLING DOOR	2006	2,878	105	27.5	105		197	43
44	REPLACE HOT WATER HEATER	2006	8,476	308	27.5	308		501	44
45	INSTALL SWING GATES WITH POSTS	2006	1,825	122	15	122		244	45
46	SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	992	15	992		1,984	46
47	INSTALL DOORS	2006	171,211	6,226	27.5	6,226		6,485	47
48									48
49	WAUKEGAN TERRACE PROPERTIES,LLC								49
50	INSTALL DOORS - FIRST FLOOR HALLWAY,CORIDOR	2007	62,358	662	27.5	662		662	50
51	INSTALL NEW DURO-LAST ROOF SYSTEM	2007	121,800	2,265	27.5	2,265		2,265	51
52	INSTALLATION OF AIR CLEANING EQUIPMENT	2007	8,736	252	27.5	252		252	52
53	AGGREGATE PANELS,FASCIA,SOFFIT-REPAIRS	2007	24,910	566	27.5	566		566	53
54	INSTALLATION OF AN ANSUL KITCHEN SYSTEM	2007	8,012	109	27.5	109		109	54
55	INSTALL TWO NEW 10 TON ROOFTOP UNITS	2007	23,380	35	27.5	35		35	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)		\$ 9,148,078	\$ 325,049		\$ 327,735	\$ 2,686	\$ 1,491,644	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	\$ 409,394	\$ 17,905	\$ 39,631	\$ 21,726	3-10	\$ 272,167	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	269,410					269,410	73
74	RELATED PARTY		35,185	35,185				74
75	TOTALS	\$ 678,804	\$ 53,090	\$ 74,816	\$ 21,726		\$ 541,577	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)	\$ 10,876,882	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 378,139	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 402,551	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,412	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,033,221	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: \$ 10,541 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	2006 FORD E350	\$ 690.00	\$ 8,330	17
18	FACILTY	2007 FORD F150	595.00	4,928	18
19	MAINTENANCE	2004 FORD F150	599.00	2,396	19
20	PAINTERS	2003 CHEV ASTRO VAN	645.00	1,822	20
21	TOTAL		\$ #####	\$ 17,476	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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
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	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs			N/A				7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ (23,487)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 92,236)	2,289,382		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,879		6
7	Other Prepaid Expenses	22,250		7
8	Accounts Receivable (owners or related parties)	447,292		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,885,316	\$	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)	(916,308)		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)	\$ 516,591	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,401,907	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 195,702	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	768,000		29
30	Accrued Salaries Payable	110,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	53,819		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)	\$ 1,127,573	\$	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)	\$ 1,127,573	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,274,334	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,401,907	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,112,245	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,112,246	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,241,088	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	(1,079,000)	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)	\$ 162,088	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)	\$ 2,274,334	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	\$ 7,907,493	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,907,493	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***	11,990	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,990	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)	\$ 7,919,483	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,222,987	31
32	Health Care	2,665,270	32
33	General Administration	1,610,648	33
	B. Capital Expense		
34	Ownership	1,064,515	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)*	\$ 6,678,395	40
41	Income before Income Taxes (line 30 minus line 40)**	1,241,088	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,241,088	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:

01/01/2007

Ending:

12/31/2007

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	2,080	2,088	\$ 71,060	\$ 34.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,226	26,421	792,267	29.99	3
4	Licensed Practical Nurses	9,847	10,261	270,313	26.34	4
5	CNAs & Orderlies	71,733	76,295	890,217	11.67	5
6	CNA Trainees					6
7	Licensed Therapist	4,207	4,585	53,802	11.73	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,849	10,453	105,992	10.14	10
11	Social Service Workers	21,359	21,791	287,281	13.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,178	25,139	268,842	10.69	15
16	Dishwashers					16
17	Maintenance Workers	10,018	10,352	137,569	13.29	17
18	Housekeepers	19,233	20,468	178,759	8.73	18
19	Laundry	8,007	8,597	80,492	9.36	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	14,859	15,590	199,940	12.82	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>	2,916	2,916	37,069	12.71	33
34	TOTAL (lines 1 - 33)	224,592	237,036	\$ 3,476,323 *	\$ 14.67	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	16,500	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fee	6,655	10-3	39
40	Physical Therapy Consultant	43	2,434	10a-3	40
41	Occupational Therapy Consultant	6	330	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	6	344	11-3	44
45	Social Service Consultant	59	3,245	12-3	45
46	Other(specify) <u>Psychiatric</u>	Monthly Fee	3,075	10-3	46
47	<u>Dental</u>	Monthly Fee	4,500	10-3	47
48					48
49	TOTAL (lines 35 - 48)	114	\$ 45,651		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	\$ 102,720	Workers' Compensation Insurance	\$ 69,431	IDPH License Fee	\$	
				Unemployment Compensation Insurance	28,649	Advertising: Employee Recruitment	3,208	
				FICA Taxes	254,352	Health Care Worker Background Check	275	
				Employee Health Insurance	97,841	(Indicate # of checks performed _____)		
				Employee Meals	10,184	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	675	MARKETING/ADV/PROMO	2,836	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	15,408	
				PENSION/PROFIT SHARING PLANS	31,838	MGMT CO ALLOC	3,176	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(2,836)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 102,720	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 22,067
				TOTAL (agree to Schedule V, line 22, col.8)				\$ 492,970
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			\$ 497,000				Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	2,860
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Entertainment Expense	()
				TOTAL			(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,860
C. Professional Services								
Vendor/Payee	Type							
ALPHA DATA	DATA PROCESSING	\$ 3,689						
WESTMONT	DATA PROCESSING	2,400						
LTC SOLUTIONS	DATA PROCESSING	1,320						
MAXXSOURCE	DATA PROCESSING	1,494						
HDSI	DATA PROCESSING	2,250						
KBKB	ACCOUNTING	15,900						
O'HALLORAN KOSOFF	LEGAL FEES	3,085						
LAWRENCE SCHWARTZ	LEGAL FEES	1,147						
PERSONNEL PLANNERS	U.C. CONSULTANT	642						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								

* 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							
																	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2004	\$ 9,626	3 YRS	\$ 1,604	\$ 3,209	\$ 3,209	\$ 1,604	\$	\$	\$	\$												
2	PAINT/DECORATING	2005	6,508	3 YRS		1,085	2,169	2,169	1,085															
3	PAINT/DECORATING	2006	2,133	3 YRS			355	711	711	356														
4																								
5																								
6																								
7																								
8																								
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20	TOTALS		\$ 18,267		\$ 1,604	\$ 4,294	\$ 5,733	\$ 4,484	\$ 1,796	\$ 356	\$	\$												

Facility Name & ID Number LAKE PARK CENTER

0027052

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. ALLIANCE FOR LIVING \$ 12600
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 10,184 Has any meal income been offset against related costs? N/A 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees