



Facility Name & ID Number LAKE PARK CENTER

# 0027052 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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			2,175	2,175	8
9	SNF/PED					9
10	ICF	71,084	550		71,634	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,084	550	2,175	73,809	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.29%**

**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 0

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

LAKE PARK CENTER

# 0027052

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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
	<b>A. General Services</b>										
1	Dietary	277,303	17,120	9,560	303,983		303,983		303,983		1
2	Food Purchase		249,430		249,430	(11,717)	237,713	(591)	237,122		2
3	Housekeeping	154,119	35,257		189,376		189,376		189,376		3
4	Laundry	91,440	12,476	1,389	105,305		105,305	6,441	111,746		4
5	Heat and Other Utilities			164,428	164,428		164,428	535	164,963		5
6	Maintenance	141,475	18,346	34,959	194,780		194,780	8,399	203,179		6
7	Other (specify):*			20,305	20,305		20,305	99	20,404		7
8	<b>TOTAL General Services</b>	664,337	332,629	230,641	1,227,607	(11,717)	1,215,890	14,883	1,230,773		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	1,945,214	93,269	20,668	2,059,151		2,059,151		2,059,151		10
10a	Therapy	57,890		809	58,699		58,699		58,699		10a
11	Activities	113,660	2,682		116,342		116,342		116,342		11
12	Social Services	290,404		2,095	292,499		292,499		292,499		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,407,168	95,951	53,572	2,556,691		2,556,691		2,556,691		16
	<b>C. General Administration</b>										
17	Administrative	102,977		496,000	598,977		598,977	(461,366)	137,611		17
18	Directors Fees										18
19	Professional Services			30,061	30,061		30,061	8,254	38,315		19
20	Dues, Fees, Subscriptions & Promotions			15,144	15,144		15,144	(10,491)	4,653		20
21	Clerical & General Office Expenses	226,107	26,903	139,982	392,992		392,992	(88,354)	304,638		21
22	Employee Benefits & Payroll Taxes			499,607	499,607	11,717	511,324		511,324		22
23	Inservice Training & Education							17	17		23
24	Travel and Seminar			4,295	4,295		4,295		4,295		24
25	Other Admin. Staff Transportation			10,803	10,803		10,803	912	11,715		25
26	Insurance-Prop.Liab.Malpractice			88,578	88,578		88,578	50,092	138,670		26
27	Other (specify):*							14,783	14,783		27
28	<b>TOTAL General Administration</b>	329,084	26,903	1,284,470	1,640,457	11,717	1,652,174	(486,153)	1,166,021		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,400,589	455,483	1,568,683	5,424,755		5,424,755	(471,270)	4,953,485		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,988
	REPAIRS & MAINTENANCE	572
		0
		9,560
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,389
		0
		1,389
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	52,760
	ELECTRICITY	58,313
	WATER	53,180
	CABLE TV - LOBBY	175
		0
		164,428
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	11,350
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,305
	ELEVATOR MAINTENANCE & REPAIR	6,383
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,528
	FIRE SERVICE	8,393
		0
		0
		0
		0
		34,959
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	14,905
	SECURITY SERVICE	5,400
		0
		0
		20,305
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	30,000
		30,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,703
	PURCHASED SERVICES	0
	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	9,440
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	150
	PSYCHIATRIC XVIII B __-2	4,875
	RN CONSULTANT XVIII B 38-2	0
	<b>DENTAL</b>	4,500
		0
		20,668
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	809
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		809
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,095
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,095
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	496,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	11,757
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	18,304
		0
		30,061
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,405
	EMPLOYEE WANT ADS XIX F	177
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	265
	LICENSES & PERMITS XIX F	332
	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	12,335
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	10
	PATIENT BACKGROUND CHECKS XIX F	120
		15,144
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,323
	EQUIPMENT REPAIR & MAINTENANCE	315
	OUTSIDE CLERICAL SERVICES	105,600
	PENALTIES / OVERDRAFT CHARGES VI 18	7,275
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,110
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	9,359
		139,982

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	251,936
	UNEMPLOYMENT COMPENSATION XIX D	12,407
	WORKERS COMPENSATION INSURANCE XIX D	63,279
	HOSPITALIZATION INSURANCE XIX D	137,473
	EMPLOYEE BENEFITS - OTHER XIX D	2,399
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	32,113
	CHICAGO HEAD TAX XIX D	0
		0
		499,607
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	4,295
	TRAVEL XIX G	0
		4,295
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	10,803
		10,803
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	88,578
		88,578
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,568,683

**LAKE PARK CENTER  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	249,430
LESS SALES TAX	<u>(591)</u>
NET FOOD	248,839

TOTAL PATIENT CENSUS	73,809
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	221,427

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

PATIENT MEALS	221,427
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	232,377

NET FOOD	248,839
DIVIDE TOTAL MEALS/YEAR	<u>232,377</u>

COST PER MEAL	1.07
TIME EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>11,717</b>
	=====

Facility Name &amp; ID Number

LAKE PARK CENTER

#0027052

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	
	<b>D. Ownership</b>											
30	Depreciation			30,816	30,816		30,816	313,943	344,759			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			393,688	393,688		393,688	654,209	1,047,897			32
33	Real Estate Taxes							147,742	147,742			33
34	Rent-Facility & Grounds			937,200	937,200		937,200	(937,200)				34
35	Rent-Equipment & Vehicles			27,738	27,738		27,738	4,138	31,876			35
36	Other (specify):* OFFICE RENT			16,380	16,380		16,380	(16,380)				36
37	<b>TOTAL Ownership</b>			1,405,822	1,405,822		1,405,822	166,452	1,572,274			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>			114,975	114,975		114,975		114,975			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,400,589	455,483	3,089,480	6,945,552		6,945,552	(304,818)	6,640,734			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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.)

Table with columns: NON-ALLOWABLE EXPENSES, Amount, Reference, BHF USE ONLY. Rows include Day Care, Other Care for Outpatients, Governmental Sponsored Special Programs, Non-Patient Meals, Telephone, TV & Radio in Resident Rooms, Rented Facility Space, Sale of Supplies to Non-Patients, Laundry for Non-Patients, Non-Straightline Depreciation, Interest and Other Investment Income, Discounts, Allowances, Rebates & Refunds, Non-Working Officer's or Owner's Salary, Sales Tax, Non-Care Related Interest, Non-Care Related Owner's Transactions, Personal Expenses (Including Transportation), Non-Care Related Fees, Fines and Penalties, Entertainment, Contributions, Owner or Key-Man Insurance, Special Legal Fees & Legal Retainers, Malpractice Insurance for Individuals, Bad Debt, Fund Raising, Advertising and Promotional, Income Taxes and Illinois Personal Property Replacement Tax, CNA Training for Non-Employees, Yellow Page Advertising, Other-Attach Schedule SEE PAGE 5A, and SUBTOTAL (A): (Sum of lines 1-29).

BHF USE ONLY table with columns 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.)

Table with columns: Amount, Reference. Rows include Non-Paid Workers-Attach Schedule\*, Donated Goods-Attach Schedule\*, Amortization of Organization & Pre-Operating Expense, Adjustments for Related Organization Costs (Schedule VII), Other- Attach Schedule, SUBTOTAL (B): (sum of lines 31-35), and TOTAL ADJUSTMENTS (A) and (B).

\*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.)

Table with columns: Yes, No, Amount, Reference. Rows include Medically Necessary Transport., Gift and Coffee Shops, Barber and Beauty Shops, Laboratory and Radiology, Prescription Drugs, Other-Attach Schedule, and TOTAL (C): (sum of lines 38-46).

LAKE PARK CENTER

ID# 0027052

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 356	6	1
2	MARKETING SALARIES	(12,000)	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	<b>Total</b>	(11,644)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number LAKE PARK CENTER

# 0027052

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(591)	0	0	0	0	0	0	0	0	0	0	(591)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	6,441	0	0	0	0	0	0	0	0	6,441	4
5	Heat and Other Utilities	0	535	0	0	0	0	0	0	0	0	0	535	5
6	Maintenance	356	2,466	2,261	3,316	0	0	0	0	0	0	0	8,399	6
7	Other (specify):*	0	26	73	0	0	0	0	0	0	0	0	99	7
8	<b>TOTAL General Services</b>	<b>(235)</b>	<b>3,027</b>	<b>8,775</b>	<b>3,316</b>	<b>0</b>	<b>14,883</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	10,018	(471,384)	0	0	0	0	0	0	0	(461,366)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	79	7,578	597	0	0	0	0	0	0	0	8,254	19
20	Fees, Subscriptions & Promotions	(14,240)	41	3,708	0	0	0	0	0	0	0	0	(10,491)	20
21	Clerical & General Office Expenses	(19,275)	12	(77,310)	8,219	0	0	0	0	0	0	0	(88,354)	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	17	0	0	0	0	0	0	0	0	17	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	627	285	0	0	0	0	0	0	0	912	25
26	Insurance-Prop.Liab.Malpractice	0	142	250	49,700	0	0	0	0	0	0	0	50,092	26
27	Other (specify):*	0	0	5,405	9,378	0	0	0	0	0	0	0	14,783	27
28	<b>TOTAL General Administration</b>	<b>(33,515)</b>	<b>274</b>	<b>(49,707)</b>	<b>(403,205)</b>	<b>0</b>	<b>(486,153)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(33,750)</b>	<b>3,301</b>	<b>(40,932)</b>	<b>(399,889)</b>	<b>0</b>	<b>(471,270)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER# 0027052

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

## 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	(5,834)	1,518	153	318,106	0	0	0	0	0	0	0	313,943	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(433,046)	2,698	0	1,084,557	0	0	0	0	0	0	0	654,209	32
33	Real Estate Taxes	0	2,094	0	145,648	0	0	0	0	0	0	0	147,742	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	669	2,924	545	0	0	0	0	0	0	0	4,138	35
36	Other (specify):*	0	(16,380)	0	0	0	0	0	0	0	0	0	(16,380)	36
37	<b>TOTAL Ownership</b>	<b>(438,880)</b>	<b>(9,401)</b>	<b>3,077</b>	<b>611,656</b>	<b>0</b>	<b>166,452</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(472,630)</b>	<b>(6,100)</b>	<b>(37,855)</b>	<b>211,767</b>	<b>0</b>	<b>(304,818)</b>	<b>45</b>						

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		" " "		535	535	2
3	V	6 PAINTERS FEES		" " "		1,077	1,077	3
4	V	6 REPAIRS/MAINT		" " "		1,389	1,389	4
5	V	7 ALARM SERVICE		" " "		26	26	5
6	V	19 ACCOUNTING FEES		" " "		79	79	6
7	V	20 LICENSES & PERMITS		" " "		41	41	7
8	V	21 OFFICE EXPENSE		" " "		12	12	8
9	V	26 INSURANCE		" " "		142	142	9
10	V	30 DEPRECIATION (SL)		" " "		1,518	1,518	10
11	V	32 INTEREST		" " "		2,698	2,698	11
12	V	33 RE TAX		" " "		2,094	2,094	12
13	V	35 STORAGE FEES		" " "		669	669	13
14	Total		\$ 16,380			\$ 10,280	\$ * (6,100)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21	OUTSIDE CLERICAL	\$ 105,600	EKS MANAGEMENT CO.		\$ (105,600)
16	V	6	PAINTERS SALARIES		" " "	2,261	2,261
17	V	7	SCAVENGER		" " "	73	73
18	V	17	CFO SALARY-A.WEINFELD		" " "	10,018	10,018
19	V	19	PROFESSIONAL FEES		" " "	7,578	7,578
20	V	20	WANT ADS/BACKGR CKS		" " "	3,708	3,708
21	V	21	TOTAL OFFICE		" " "	28,290	28,290
22	V	23	SEMINAR		" " "	17	17
23	V	25	TRANSPORTATION		" " "	627	627
24	V	26	INSURANCE		" " "	250	250
25	V	27	EMPLOYEE BENEFITS		" " "	5,405	5,405
26	V	30	DEPRECIATION (SL)		" " "	153	153
27	V	35	EQUIPMENT RENT		" " "	2,924	2,924
28	V	4	HOUSEKEEPING SALARIES		" " "	6,441	6,441
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 105,600			\$ 67,745	\$ * (37,855)

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

Facility Name &amp; ID Number

LAKE PARK CENTER

# 0027052

Report Period Beginning:

01/01/2009

Ending: 12/31/2009

## 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	\$ 496,000	EMI ENTERPRISES INC.		\$ (496,000)	15
16	V	17	M. ESFORMES, OFFICER		" " "	16,992	16,992	16
17	V	19	ACCOUNTING FEES		" " "	597	597	17
18	V	21	TOTAL OFFICE		" " "	8,219	8,219	18
19	V	25	TRANSPORTATION		" " "	285	285	19
20	V	26	INSURANCE		" " "	1,078	1,078	20
21	V	27	EMPLOYEE BENEFITS		" " "	9,378	9,378	21
22	V	35	AUTO LEASE		" " "	545	545	22
23	V	6	DRIVERS SALARY		" " "	3,316	3,316	23
24	V	17	REGIONAL DIRECTOR		" " "	7,624	7,624	24
25	V	30	DEPRECIATION (SL )		" " "	67	67	25
26	V							26
27	V							27
28	V	34	RENT	937,200	WAUKEGAN TERRACE PROPERTIES LLC		(937,200)	28
29	V	33	REAL ESTATE TAX		" " " "	145,648	145,648	29
30	V	30	DEPRECIATION ( SL )		" " " "	318,039	318,039	30
31	V	32	INTEREST		" " " "	545,264	545,264	31
32	V	32	MORTGAGE INSURANCE		" " " "	539,293	539,293	32
33	V	26	INSURANCE		" " " "	48,622	48,622	33
34	V					12,040	12,040	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,433,200			\$ 1,657,007	\$ * 223,807	39

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

Facility Name &amp; ID Number

LAKE PARK CENTER

#

0027052

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			SALARY	\$ 16,992	17-8	1
2	AVRUM WEINFELD	CFO	CFO	1.43	ATTACHED SCHEDULE			SALARY	10,018	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,010		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:

01/01/2009

Ending: 2/31/2009

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 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

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	847,051	14	\$ 25,953	\$ 25,953	73,809	\$ 2,261	1
2	7	SCAVENGER	PATIENT DAYS	847,051	14	842		73,809	73	2
3	17	CFO SALARY-A.WEINFELD	PATIENT DAYS	847,051	14	114,971	114,971	73,809	10,018	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	74,170	73,809	7,578	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	847,051	14	42,556		73,809	3,708	5
6	21	TOTAL OFFICE	PATIENT DAYS	847,051	14	324,660	230,236	73,809	28,290	6
7	23	SEMINAR	PATIENT DAYS	847,051	14	190		73,809	17	7
8	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		73,809	627	8
9	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		73,809	250	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		73,809	5,405	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	847,051	14	1,757		73,809	153	11
12	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		73,809	2,924	12
13	4	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	73,923	73,923	73,809	6,441	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					\$ 777,478	\$ 519,253		\$ 67,745	25

Facility Name & ID Number LAKE PARK CENTER

# 0027052 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	187,059	14	\$ 6,106	\$ 16,380	\$ 535	1
2	6	PAINTERS FEES	INCOME	187,059	14	12,303	16,380	1,077	2
3	6	REPAIRS/MAINT	INCOME	187,059	14	15,863	16,380	1,389	3
4	7	ALARM SERVICE	INCOME	187,059	14	301	16,380	26	4
5	19	ACCOUNTING FEES	INCOME	187,059	14	897	16,380	79	5
6	20	LICENSES & PERMITS	INCOME	187,059	14	468	16,380	41	6
7	21	OFFICE EXPENSE	INCOME	187,059	14	136	16,380	12	7
8	26	INSURANCE	INCOME	187,059	14	1,627	16,380	142	8
9	30	DEPRECIATION (SL)	INCOME	187,059	14	17,336	16,380	1,518	9
10	32	INTEREST	INCOME	187,059	14	30,806	16,380	2,698	10
11	33	RE TAX	INCOME	187,059	14	23,914	16,380	2,094	11
12	35	STORAGE FEES	INCOME	187,059	14	7,635	16,380	669	12
13	35								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					\$ 117,392	\$	\$ 10,280	25

Facility Name & ID Number LAKE PARK CENTER

# 0027052 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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	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	17	M. ESFORMES OFFICER	PATIENT DAYS	847,051	14	\$ 195,000	\$ 73809	\$ 16,992	1
2	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850	73809	597	2
3	21	TOTAL OFFICE	PATIENT DAYS	847,051	14	94,319	58,251	73809	8,219
4	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276	73809	285	4
5	26	INSURANCE	PATIENT DAYS	847,051	14	12,367	73809	1,078	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628	73809	9,378	6
7	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253	73809	545	7
8	6	DRIVERS SALARY	PATIENT DAYS	847,051	14	38,060	38,060	73809	3,316
9	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	73809	7,624	9
10	30	DEPRECIATION (SL )	PATIENT DAYS	847,051	14	765	73809	67	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					\$ 552,018	\$ 96,311	\$ 48,101	25

Facility Name &amp; ID Number

LAKE PARK CENTER

# 0027052

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	RELATED PARTY: WAUKEGAN TERRACE PROPERTIES, LLC						\$	\$			\$	1					
2	CAMBRIDGE REALTY		X	MORTGAGE	\$75,439.10	04/04	10,324,600	9,692,936	04/39	5.1400	539,293	2					
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		192,242				5,971	3					
4	MIP INSURANCE		X								48,622	4					
5												5					
	<b>Working Capital</b>																
6	THE PRIVATE BANK		X	WORKING CAPITAL	DEMAND	01/08	1,215,000	1,255,000		PRIME+	25,329	6					
7												7					
8	IME REALTY ALLOCATIONS										2,698	8					
9	<b>TOTAL Facility Related</b>				\$75,439.10		\$ 11,731,842	\$ 10,947,936			\$ 621,913	9					
	<b>B. Non-Facility Related*</b>																
10	THE PRIVATE BANK		X	LOAN	DEMAND	01/15/08	5,155,000	4,820,563	01/31/13	PRIME+	306,059	10					
11	M. ESFORMES		X	LOAN		01/15/08	1,000,000	1,000,000			45,000	11					
12	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		86,500	53,343			17,300	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$ 6,241,500	\$ 5,873,906			\$ 368,359	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 17,973,342	\$ 16,821,842			\$ 990,272	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 48,622 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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>134,215</b>	<b>1</b>
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.)		\$	<b>138,204</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,989</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>141,659</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>145,648</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>125,610</b>	<b>8</b>
	2005	<b>127,086</b>	<b>9</b>
	2006	<b>130,420</b>	<b>10</b>
	2007	<b>130,941</b>	<b>11</b>
	2008	<b>138,204</b>	<b>12</b>

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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 2008 TAX BILL**

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 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 2008 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 2008.

	(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>138,203.54</u>	\$ <u>138,203.54</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>138,203.54</u>	\$ <u>138,203.54</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number LAKE PARK CENTER

# 0027052

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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	NURSING HOME		2003	\$ 1,050,000	1
2					2
3	TOTALS			\$ 1,050,000	3

Facility Name &amp; ID Number LAKE PARK CENTER

# 0027052

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**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		\$ 1,838,747	4
5											5
6											6
7											7
8		IME ALLOCATION				1,458		1,458			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		41,995	11
12		ROOFING		1989	56,815	1,804	31.5	1,804		36,381	12
13		CUBICLE CURTAIN & TILE		1991	20,473	650	31.5	650		11,998	13
14		PARKING LOTS		1993	19,440		15			19,440	14
15		CUBICLE CURTAINS		1993	1,796	46	31.5	46		834	15
16		NURSE STATION		1993	7,800	200	31.5	200		3,622	16
17		ELEVATOR		1994	22,300	572	39	572		8,842	17
18		CUBICLE CURTAINS		1994	843	22	39	22		347	18
19		PARKING LOTS LIGHTS		1995	8,677	578	15	578		8,381	19
20		REPAIR STONE FASCIA		1995	9,750	250	39	250		3,615	20
21		INSULATE SUPPLY/DUCT WORK		1995	7,190	185	39	185		2,620	21
22		TILE		1996	20,387	522	39	522		6,940	22
23		WEATHER-ROOFTOP		1997	6,408	164	39	164		1,975	23
24		METAL DOORS & AIR CONDITION		1998	11,993	308	39	308		3,657	24
25		TWO SHOWERS		1998	2,720	70	39	70		825	25
26		NEW ROOFING SYSTEM ABOVE KITCHEN		1998	9,800	251	39	251		2,876	26
27		CABINERY-ADM., BOOKKEPING, DON		1998	33,000	846	39	846		9,553	27
28		WATER HEATER		1998	4,639	119	39	119		1,324	28
29		INSTALLED SMOKE AND DUST DETECTORS		1999	4,572	117	39	117		1,234	29
30		FURNISH AND INSTALL FIRE DAMPERS		1999	25,971	666	39	666		6,910	30
31		FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE		1999	18,547	476	39	476		4,780	31
32		WATER HEATER, HEAT EXCHANGER, HOT WATER TANK		1999	8,640	222	39	222		2,248	32
33		FIRE DAMPERS		2000	8,070	293	20	293		2,796	33
34		FENCE		2000	6,810	477	15	477		4,346	34
35		CUBICLE CURTAINS		2001	14,018		20	701	701	6,309	35
36		ROOF MAINTENANCE & FLASHING REPAIR		2001	6,950	253	27.5	253		2,277	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number LAKE PARK CENTER

# 0027052

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 PAINT ALL INTERIOR WALLS	2001	\$ 2,800	\$ 102	27.5	\$ 102	\$	\$ 918	37
38 IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895		20	2,245	2,245	20,205	38
39 DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		9,432	39
40 ROOF TOP UNITS	2001	12,900	469	27.5	469		4,221	40
41 INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		9,106	41
42 INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		3,500	42
43 INSTALL STEEL ROLLING DOOR	2006	2,878	105	27.5	105		407	43
44 REPLACE HOT WATER HEATER	2006	8,476	308	27.5	308		1,117	44
45 INSTALL SWING GATES WITH POSTS	2006	1,825	122	15	122		488	45
46 SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	992	15	992		3,968	46
47 INSTALL DOORS	2006	171,211	6,226	27.5	6,226		18,937	47
48								48
49								49
50								50
51								51
52								52
53								53
54 WAUKEGAN TERRACE PROPERTIES,LLC								54
55 INSTALL DOORS - FIRST FLOOR HALLWAY,CORIDOR	2007	62,358	2,268	27.5	2,268		5,198	55
56 INSTALL NEW DURO-LAST ROOF SYSTEM	2007	121,800	4,429	27.5	4,429		11,123	56
57 INSTALLATION OF AIR CLEANING EQUIPMENT	2007	8,736	318	27.5	318		888	57
58 AGGREGATE PANELS,FASCIA,SOFFIT-REPAIRS	2007	24,910	906	27.5	906		2,378	58
59 INSTALLATION OF AN ANSUL KITCHEN SYSTEM	2007	8,012	291	27.5	291		691	59
60 INSTALL TWO NEW 10 TON ROOFTOP UNITS	2007	23,380	850	27.5	850		1,735	60
61 REPLACE TRANE HEAT EXCHANGER FOR ROOFTOP UNIT	2008	3,925	143	27.5	143		161	61
62 FURNISH AND INSTALLED FOUR DAMPERS	2009	5,340	121	27.5	121		121	62
63 MOUNTING 18 CLOSERS, INSTALL NEW DOOR STOP	2009	4,700	129	27.5	129		129	63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 9,162,043	\$ 329,383		\$ 332,069	\$ 2,686	\$ 2,153,455	70

\*\*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:

01/01/2009

Ending:

12/31/2009

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	\$ 353,884	\$ 8,520	\$	\$ (8,520)	3-15	\$ 288,548	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	324,919					324,919	73
74	<b>RELATED PARTY SL DEPRECIATION</b>		12,690	12,690				74
75	<b>TOTALS</b>	\$ 678,803	\$ 21,210	\$ 12,690	\$ (8,520)		\$ 613,467	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 10,890,846	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 350,593	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 344,759	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,834)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,766,922	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	<b>TOTALS</b>	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number LAKE PARK CENTER

STATE OF ILLINOIS

# 0027052

Report Period Beginning:

01/01/2009

Ending: 12/31/2009

**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	<b>TOTAL</b>				\$			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: \$ 9,560

Description: COPY MACHINE - \$ 7,411 AND PUBLIC STORAGE - \$ 2,149

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>FACILITY</u>	<u>2006 FORD E350</u>	\$ <u>690.00</u>	\$ <u>8,430</u>	17
18	<u>FACILITY</u>	<u>2007 FORD F150</u>	<u>595.00</u>	<u>7,140</u>	18
19	<u>PAINTERS</u>	<u>2009 FORD XL VAN</u>		<u>2,608</u>	19
20					20
21	<b>TOTAL</b>		\$ <u>#####</u>	\$ <u>18,178</u>	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. \_\_\_\_\_ \$ \_\_\_\_\_  
 13. \_\_\_\_\_ \$ \_\_\_\_\_  
 14. \_\_\_\_\_ \$ \_\_\_\_\_

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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							7	
8	Habilitation		hrs			N/A				8	
9	Pharmacy	39-2	# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$		\$	\$		\$	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 &amp; ID Number LAKE PARK CENTER

# 0027052

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 31,260	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 92,236 )	3,056,993		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,147		6
7	Other Prepaid Expenses	1,081		7
8	Accounts Receivable (owners or related parties)	831,871		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,044,352	\$	10
	<b>B. Long-Term Assets</b>			
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)	(984,250)		17
18	Deferred Charges	86,500		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Amort of Defer Loan Costs</u>	(33,157)		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 501,992	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,546,344	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 179,608	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,255,000		29
30	Accrued Salaries Payable	115,193		30
31	Accrued Taxes Payable (excluding real estate taxes)	47,047		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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,596,848	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	5,820,563		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,820,563	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 7,417,411	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (2,871,067)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,546,344	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(2,995,932)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>2</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(2,995,930)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,561,986</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,437,123)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>124,863</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,871,067)</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,459,797	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,459,797	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	64,687	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 64,687	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,524,484	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,227,607	31
32	Health Care	2,556,691	32
33	General Administration	1,640,457	33
<b>B. Capital Expense</b>			
34	Ownership	1,405,822	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	114,975	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,945,552	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,578,932	41
42	<b>Income Taxes</b>	(16,946)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,561,986	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:

01/01/2009

Ending:

12/31/2009

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	2,080	\$ 70,503	\$ 33.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,993	23,577	677,599	28.74	3
4	Licensed Practical Nurses	11,015	11,611	304,795	26.25	4
5	CNAs & Orderlies	65,307	68,225	822,447	12.05	5
6	CNA Trainees					6
7	Licensed Therapist	4,526	4,846	57,890	11.95	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,477	11,077	113,660	10.26	10
11	Social Service Workers	19,732	20,420	290,404	14.22	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	78,437	37.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,644	19,786	198,866	10.05	15
16	Dishwashers					16
17	Maintenance Workers	8,747	8,905	141,475	15.89	17
18	Housekeepers	15,612	16,362	154,119	9.42	18
19	Laundry	8,518	9,096	91,440	10.05	19
20	Administrator	2,080	2,080	102,977	49.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,734	17,670	226,107	12.80	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 <u>Quality Assurance</u>	2,167	2,167	69,870	32.24	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,712	219,982	\$ 3,400,589 *	\$ 15.46	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	\$ 8,988	1-3	35
36	Medical Director	Monthly	30,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	9,440	10-3	39
40	Physical Therapy Consultant	12	809	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	37	2,095	12-3	45
46	Other(specify) <u>Physicians</u>	Monthly	150	10-3	46
47	<u>Psychiatric</u>	Monthly	4,875	10-3	47
48	<u>Dental</u>	Monthly	4,500	10-3	48
49	TOTAL (lines 35 - 48)	49	\$ 60,857		49

C. CONTRACT NURSES

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
BRIAN LIVINGS	ADMINISTRATOR	0	\$ 102,977	Workers' Compensation Insurance		\$ 63,279	IDPH License Fee	\$	
				Unemployment Compensation Insurance		12,407	Advertising: Employee Recruitment	177	
				FICA Taxes		251,936	Health Care Worker Background Check	10	
				Employee Health Insurance		137,473	(Indicate # of checks performed	1	
				Employee Meals		11,717	Patient Background Checks	3	
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	12,835	
				EMPLOYEE BENEFITS - OTHER		2,399	MARKETING/ADV/PROMO	1,405	
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	597	
				PENSION/PROFIT SHARING PLANS		32,113	MGMT CO ALLOC	3,749	
				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(12,835)	
				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(1,405)	
							Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 102,977				\$ 511,324			\$ 4,653		
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			\$ 496,000			\$	Out-of-State Travel	\$	
							In-State Travel	0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
\$ 496,000				\$			\$ 4,295		
C. Professional Services									
Vendor/Payee	Type		Amount						
ALPHA DATA	DATA PROCESSING		\$ 3,930						
WESTMONT	DATA PROCESSING		2,650						
LTC SOLUTIONS	DATA PROCESSING		1,500						
MAXXSOURCE	DATA PROCESSING		1,321						
HDSI	DATA PROCESSING		2,356						
KBKB	ACCOUNTING		15,900						
PERSONNEL PLANNERS	U.C. CONSULTANT		652						
THE KARMEI LAW FIRM	LEGAL FEES		672						
MPRO	DISPUTE RESOLUTION SERV		1,080						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
\$ 30,061									

\* 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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	2006	\$ 2,133	3 YRS	\$ 355	\$ 711	\$ 711	\$ 356	\$	\$	\$	\$
2												
3												
4												
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13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 2,133		\$ 355	\$ 711	\$ 711	\$ 356	\$	\$	\$	\$

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 \$ 265
- (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. \$ 0 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. \$ 11,717 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: \_\_\_\_\_
- (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.