FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0027052

Facility Name: LAKE PARK CENTER

Address: 919 WASHINGTON PARK (Number) WAUKEGAN (City) 60085 (Zip Code)

County: LAKE

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,492	2,492	8
9	SNF/PED					9
10	ICF	70,299	1,094		71,393	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,299	1,094	2,492	73,885	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.39%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 02/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	283,996	13,852	9,197	307,045		307,045		307,045			1
2	Food Purchase		256,087		256,087	(12,045)	244,042	(417)	243,625			2
3	Housekeeping	166,417	42,216		208,633		208,633	1,049	209,682			3
4	Laundry	103,250	12,736	1,306	117,292		117,292		117,292			4
5	Heat and Other Utilities			165,399	165,399		165,399	506	165,905			5
6	Maintenance	134,151	18,911	32,805	185,867		185,867	9,467	195,334			6
7	Other (specify):*			21,434	21,434		21,434	92	21,526			7
8	**TOTAL General Services**	687,814	343,802	230,141	1,261,757	(12,045)	1,249,712	10,697	1,260,409			8
	B. Health Care and Programs											
9	Medical Director			30,204	30,204		30,204		30,204			9
10	Nursing and Medical Records	2,007,534	92,345	21,208	2,121,087		2,121,087		2,121,087			10
10a	Therapy	52,863			52,863		52,863		52,863			10a
11	Activities	116,622	3,474	299	120,395		120,395		120,395			11
12	Social Services	287,389		3,156	290,545		290,545		290,545			12
13	CNA Training											13
14	Program Transportation			1,354	1,354		1,354		1,354			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,464,408	95,819	56,221	2,616,448		2,616,448		2,616,448			16
	C. General Administration											
17	Administrative	109,973		469,000	578,973		578,973	(436,299)	142,674			17
18	Directors Fees											18
19	Professional Services			32,116	32,116		32,116	7,526	39,642			19
20	Dues, Fees, Subscriptions & Promotions			15,000	15,000		15,000	(9,851)	5,149			20
21	Clerical & General Office Expenses	244,069	30,769	127,101	401,939		401,939	(72,482)	329,457			21
22	Employee Benefits & Payroll Taxes			525,237	525,237	12,045	537,282		537,282			22
23	Inservice Training & Education							15	15			23
24	Travel and Seminar			2,510	2,510		2,510		2,510			24
25	Other Admin. Staff Transportation			13,149	13,149		13,149	1,243	14,392			25
26	Insurance-Prop.Liab.Malpractice			87,681	87,681		87,681	12,881	100,562			26
27	Other (specify):*			181,143	181,143		181,143	(164,860)	16,283			27
28	**TOTAL General Administration**	354,042	30,769	1,452,937	1,837,748	12,045	1,849,793	(661,827)	1,187,966			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,506,264	470,390	1,739,299	5,715,953		5,715,953	(651,130)	5,064,823			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.

Facility Name & ID#: LAKE PARK CENTER **#0027052** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,614	
	REPAIRS & MAINTENANCE		583	
			0	9,197
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,306	
			0	1,306
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		44,974	
	ELECTRICITY		65,016	
	WATER		55,205	
	CABLE TV - LOBBY		204	
			0	165,399
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		11,748	
	PAINTING & DECORATING		158	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,344	
	ELEVATOR MAINTENANCE & REPAIR		7,333	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,528	
	FIRE SERVICE		5,694	
			0	
			0	
			0	
			0	32,805
7	**OTHER**			
	SCAVENGER		16,034	
	SECURITY SERVICE		5,400	
			0	
			0	21,434
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	30,204	30,204

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		69	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	10,080	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	6,559	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		4,500	
			0	21,208
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	299	
			0	299
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,156	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,156
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKE PARK CENTER **#0027052** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,354	1,354
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	469,000	469,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,947	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	20,169	
			0	32,116
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	227	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	113	
	LICENSES & PERMITS	XIX F	833	
	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	12,487	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	840	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				15,000
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		30	
	EQUIPMENT REPAIR & MAINTENANCE		235	
	OUTSIDE CLERICAL SERVICES		105,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,128	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		6,108	127,101

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	256,318	
	UNEMPLOYMENT COMPENSATION	XIX D	14,083	
	WORKERS COMPENSATION INSURANC	XIX D	70,878	
	HOSPITALIZATION INSURANCE	XIX D	144,537	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,379	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	38,042	
	CHICAGO HEAD TAX	XIX D	0	
			0	525,237
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,510	
	TRAVEL	XIX G	0	
				2,510
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,149	
				13,149
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		87,681	
				87,681
27	**OTHER**			
	BAD DEBTS	VI 24	181,143	
				181,143

GRAND TOTAL COLUMN 3 OTHER **1,739,299**

LAKE PARK CENTER
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	256,087
LESS SALES TAX	(417)
NET FOOD	255,670
TOTAL PATIENT CENSUS	73,885
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	221,655
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	221,655
ADD EMPLOYEE MEALS	10,950
TOTAL MEALS/YEAR	232,605
NET FOOD	255,670
DIVIDE TOTAL MEALS/YEAR	232,605
COST PER MEAL	1.10
TIME EMPLOYEE MEALS	10,950
EMPLOYEE MEAL RECLASSIFICATION	**12,045**
	========

Facility Name & ID Number LAKE PARK CENTER #0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,832	24,832		24,832	345,083	369,915			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			377,530	377,530		377,530	96,639	474,169			32
33	Real Estate Taxes							151,272	151,272			33
34	Rent-Facility & Grounds			948,200	948,200		948,200	(948,200)				34
35	Rent-Equipment & Vehicles			26,983	26,983		26,983	3,662	30,645			35
36	Other (specify):* **OFFICE RENT**			16,380	16,380		16,380	31,301	47,681			36
37	**TOTAL Ownership**			1,393,925	1,393,925		1,393,925	(320,243)	1,073,682			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)**	3,506,264	470,390	3,248,199	7,224,853		7,224,853	(971,373)	6,253,480			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: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	34,180	30		9
10	Interest and Other Investment Income	(86,143)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(417)	2		13
14	Non-Care Related Interest	(357,824)	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	(12,987)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(181,143)	27		24
25	Fund Raising, Advertising and Promotional	(227)	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 SEE PAGE 5A	(12,000)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (616,561)		$	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 Amount	2 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)	(354,812)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (354,812)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (971,373)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						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: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		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
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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**	(12,000)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(417)	0	0	0	0	0	0	0	0	0	0	(417)	2
3	Housekeeping	0	0	1,049	0	0	0	0	0	0	0	0	1,049	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	506	0	0	0	0	0	0	0	0	0	506	5
6	Maintenance	0	1,847	4,159	3,461	0	0	0	0	0	0	0	9,467	6
7	Other (specify):*	0	53	39	0	0	0	0	0	0	0	0	92	7
8	**TOTAL General Services**	(417)	2,406	5,247	3,461	0	0	0	0	0	0	0	10,697	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	10,049	(446,348)	0	0	0	0	0	0	0	(436,299)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	87	6,869	570	0	0	0	0	0	0	0	7,526	19
20	Fees, Subscriptions & Promotions	(13,214)	85	3,278	0	0	0	0	0	0	0	0	(9,851)	20
21	Clerical & General Office Expenses	(12,000)	24	(70,197)	9,691	0	0	0	0	0	0	0	(72,482)	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	15	0	0	0	0	0	0	0	0	15	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	1,043	200	0	0	0	0	0	0	0	1,243	25
26	Insurance-Prop.Liab.Malpractice	0	106	444	12,331	0	0	0	0	0	0	0	12,881	26
27	Other (specify):*	(181,143)	0	5,378	10,905	0	0	0	0	0	0	0	(164,860)	27
28	**TOTAL General Administration**	(206,357)	302	(43,121)	(412,651)	0	0	0	0	0	0	0	(661,827)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(206,774)	2,708	(37,874)	(409,190)	0	0	0	0	0	0	0	(651,130)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	34,180	1,520	134	309,249	0	0	0	0	0	0	0	345,083	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(443,967)	2,630	0	537,976	0	0	0	0	0	0	0	96,639	32
33	Real Estate Taxes	0	2,129	0	149,143	0	0	0	0	0	0	0	151,272	33
34	Rent-Facility & Grounds	0	0	0	(948,200)	0	0	0	0	0	0	0	(948,200)	34
35	Rent-Equipment & Vehicles	0	697	2,543	422	0	0	0	0	0	0	0	3,662	35
36	Other (specify):*	0	(16,380)	0	47,681	0	0	0	0	0	0	0	31,301	36
37	**TOTAL Ownership**	(409,787)	(9,404)	2,677	96,271	0	0	0	0	0	0	0	(320,243)	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)**	(616,561)	(6,696)	(35,197)	(312,919)	0	0	0	0	0	0	0	(971,373)	45

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.		HOME OFFICE
				WAUKEGAN	LINCOLNWOOD	
				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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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				506	506	2
3	V	6	PAINTERS FEES				539	539	3
4	V	6	REPAIRS/MAINT				1,308	1,308	4
5	V	7	ALARM SERVICE				53	53	5
6	V	19	ACCOUNTING FEES				87	87	6
7	V	20	LICENSES & PERMITS				85	85	7
8	V	21	OFFICE EXPENSE				24	24	8
9	V	26	INSURANCE				106	106	9
10	V	30	DEPRECIATION (SL)				1,520	1,520	10
11	V	32	INTEREST				2,630	2,630	11
12	V	33	RE TAX				2,129	2,129	12
13	V	35	STORAGE FEES				697	697	13
14	Total			$ 16,380			$ 9,684	$ * (6,696)	14

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 105,600	EKS MANAGEMENT CO.		$	$ (105,600)	15
16	V	6	PAINTERS SALARIES				4,159	4,159	16
17	V	7	SCAVENGER				39	39	17
18	V	17	CFO SALARY-A.WEINFELD				10,049	10,049	18
19	V	19	PROFESSIONAL FEES				6,869	6,869	19
20	V	20	WANT ADS/BACKGR CKS				3,278	3,278	20
21	V	21	TOTAL OFFICE				35,403	35,403	21
22	V	23	SEMINAR				15	15	22
23	V	25	TRANSPORTATION				1,043	1,043	23
24	V	26	INSURANCE				444	444	24
25	V	27	EMPLOYEE BENEFITS				5,378	5,378	25
26	V	30	DEPRECIATION (SL)				134	134	26
27	V	35	EQUIPMENT RENT				2,543	2,543	27
28	V	3	HOUSEKEEPING SALARIES				1,049	1,049	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 105,600			$ 70,403	$ * (35,197)	39

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 469,000	EMI ENTERPRISES		$	$ (469,000)	15
16	V	17	M. ESFORMES, OFFICER				17,045	17,045	16
17	V	19	ACCOUNTING FEES				570	570	17
18	V	21	TOTAL OFFICE				9,691	9,691	18
19	V	25	TRANSPORTATION				200	200	19
20	V	26	INSURANCE				913	913	20
21	V	27	EMPLOYEE BENEFITS				10,905	10,905	21
22	V	35	AUTO LEASE				422	422	22
23	V	6	DRIVERS SALARY				3,461	3,461	23
24	V	17	REGIONAL DIRECTOR				5,607	5,607	24
25	V								25
26	V								26
27	V								27
28	V	34	RENT	948,200	WAUKEGAN TERRACE PROPERTIES LLC			(948,200)	28
29	V	33	REAL ESTATE TAX				149,143	149,143	29
30	V	30	DEPRECIATION (SL)				309,249	309,249	30
31	V	32	INTEREST				532,005	532,005	31
32	V	32	AMORT LOAN COST				5,971	5,971	32
33	V	26	INSURANCE				11,418	11,418	33
34	V	36	MIP INSURANCE				47,681	47,681	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,417,200			$ 1,104,281	$ * (312,919)	39

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES	GENERAL PTR	ADMINISTRATIV	87.61	SEE			SALARY	$ 17,045	17-8	1
2	AVRUM WEINFELD	CFO	CFO	1.43	ATTACHED			SALARY	10,049	17-8	2
3					SCHEDULE						3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,094		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: 01/01/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	PATIENT DAYS	845,281	14	$ 47,580	$ 47,580	73,885	$ 4,159	1
2	7	SCAVENGER	PATIENT DAYS	845,281	14	441		73,885	39	2
3	17	CFO SALARY-A.WEINFELD	PATIENT DAYS	845,281	14	114,971	114,971	73,885	10,049	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	845,281	14	78,585	66,116	73,885	6,869	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	845,281	14	37,500		73,885	3,278	5
6	21	TOTAL OFFICE	PATIENT DAYS	845,281	14	405,027	295,327	73,885	35,403	6
7	23	SEMINAR	PATIENT DAYS	845,281	14	175		73,885	15	7
8	25	TRANSPORTATION	PATIENT DAYS	845,281	14	11,931		73,885	1,043	8
9	26	INSURANCE	PATIENT DAYS	845,281	14	5,077		73,885	444	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	61,528		73,885	5,378	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	845,281	14	1,536		73,885	134	11
12	35	EQUIPMENT RENT	PATIENT DAYS	845,281	14	29,093		73,885	2,543	12
13	3	HOUSEKEEPING SALARIES	PATIENT DAYS	845,281	14	12,000		73,885	1,049	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					$ 805,444	$ 523,994		$ 70,403	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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	INCOME	187,059	14	$ 5,775	$	16,380	$ 506	1
2	6	PAINTERS FEES	INCOME	187,059	14	6,152		16,380	539	2
3	6	REPAIRS/MAINT	INCOME	187,059	14	14,941		16,380	1,308	3
4	7	ALARM SERVICE	INCOME	187,059	14	601		16,380	53	4
5	19	ACCOUNTING FEES	INCOME	187,059	14	998		16,380	87	5
6	20	LICENSES & PERMITS	INCOME	187,059	14	971		16,380	85	6
7	21	OFFICE EXPENSE	INCOME	187,059	14	274		16,380	24	7
8	26	INSURANCE	INCOME	187,059	14	1,211		16,380	106	8
9	30	DEPRECIATION (SL)	INCOME	187,059	14	17,356		16,380	1,520	9
10	32	INTEREST	INCOME	187,059	14	30,039		16,380	2,630	10
11	33	RE TAX	INCOME	187,059	14	24,313		16,380	2,129	11
12	35	STORAGE FEES	INCOME	187,059	14	7,961		16,380	697	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					$ 110,592	$		$ 9,684	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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	M. ESFORMES OFFICER	PATIENT DAYS	845,281	14	$ 195,000	$ 195,000	73,885	$ 17,045	1
2	19	ACCOUNTING FEES	PATIENT DAYS	845,281	14	6,525		73,885	570	2
3	21	TOTAL OFFICE	PATIENT DAYS	845,281	14	110,874	58,558	73,885	9,691	3
4	25	TRANSPORTATION	PATIENT DAYS	845,281	14	2,287		73,885	200	4
5	26	INSURANCE	PATIENT DAYS	845,281	14	10,450		73,885	913	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	845,281	14	124,762		73,885	10,905	6
7	35	AUTO LEASE	PATIENT DAYS	845,281	14	4,824		73,885	422	7
8	6	DRIVERS SALARY	PATIENT DAYS	845,281	14	39,600	39,600	73,885	3,461	8
9	17	REGIONAL DIRECTOR	PATIENT DAYS	845,281	14	64,150	64,150	73,885	5,607	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 558,472	$ 357,308		$ 48,814	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	9,557,789	04/39	5.1400	532,005	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			196,243	155,937			5,971	3
4												4
5	RELATED PARTY										2,630	5
	Working Capital											
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	01/08	1,215,000			PRIME+	19,706	6
7												7
8	IME REALTY ALLOCATIONS											8
9	TOTAL Facility Related				$75,439.10		$ 11,735,843	$ 9,713,726			$ 560,312	9
	B. Non-Facility Related*											
10	THE PRIVATE BANK		X	LOAN	DEMAND	01/15/08	5,155,000	4,628,973	01/31/13	PRIME+	295,633	10
11	M. ESFORMES		X	LOAN		01/15/08	1,000,000	284,470			44,887	11
12	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			86,500	36,039			17,304	12
13												13
14	TOTAL Non-Facility Related						$ 6,241,500	$ 4,949,482			$ 357,824	14
15	TOTALS (line 9+line14)						$ 17,977,343	$ 14,663,208			$ 918,136	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 47,681 **Line #** 36

*** 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.)**

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	141,659	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.)	$	143,252	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,593	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	147,550	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	149,143	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	127,086	8
2006	130,420	9
2007	130,941	10
2008	138,204	11
2009	143,252	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-400-032	NURSING HOME	$ 143,252.39	$ 143,252.39
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 143,252.39	$ 143,252.39

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

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 [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2003	$ 1,050,000	1
2					2
3	TOTALS			$ 1,050,000	3

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210		2003	1967	$ 8,144,786	$ 296,174	27.5	$ 296,174	$	$ 2,134,921	4
5											5
6											6
7											7
8	IME ALLOCATION					1,460		1,460			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		43,424	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		38,185	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		12,648	13
14	PARKING LOTS			1993	19,440		15			19,440	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	46		880	15
16	NURSE STATION			1993	7,800	200	31.5	200		3,822	16
17	ELEVATOR			1994	22,300	572	39	572		9,414	17
18	CUBICLE CURTAINS			1994	843	22	39	22		369	18
19	PARKING LOTS LIGHTS			1995	8,677	296	15	296		8,677	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		3,865	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		2,805	21
22	TILE			1996	20,387	522	39	522		7,462	22
23	WEATHER-ROOFTOP			1997	6,408	164	39	164		2,139	23
24	METAL DOORS & AIR CONDITION			1998	11,993	308	39	308		3,965	24
25	TWO SHOWERS			1998	2,720	70	39	70		895	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		3,127	26
27	CABINNERY-ADM., BOOKKEPING, DON			1998	33,000	846	39	846		10,399	27
28	WATER HEATER			1998	4,639	119	39	119		1,443	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		1,351	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		7,576	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE			1999	18,547	476	39	476		5,256	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK			1999	8,640	222	39	222		2,470	32
33	FIRE DAMPERS			2000	8,070	293	20	293		3,089	33
34	FENCE			2000	6,810	409	15	409		4,755	34
35	CUBICLE CURTAINS			2001	14,018		20	701	701	7,010	35
36	ROOF MAINTENANCE & FLASHING REPAIR			2001	6,950	253	27.5	253		2,530	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 & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINT ALL INTERIOR WALLS	2001	$ 2,800	$ 102	27.5	$ 102	$	$ 1,020	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895		20	2,245	2,245	22,450	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		10,480	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		4,690	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		10,384	41
42	INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		4,366	42
43	INSTALL STEEL ROLLING DOOR	2006	2,878	105	27.5	105		512	43
44	REPLACE HOT WATER HEATER	2006	8,476	308	27.5	308		1,425	44
45	INSTALL SWING GATES WITH POSTS	2006	1,825	122	15	122		610	45
46	SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	992	15	992		4,960	46
47	INSTALL DOORS	2006	171,211	6,226	27.5	6,226		25,163	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		7,466	55
56	INSTALL NEW DURO-LAST ROOF SYSTEM	2007	121,800	4,429	27.5	4,429		15,552	56
57	INSTALLATION OF AIR CLEANING EQUIPMENT	2007	8,736	318	27.5	318		1,206	57
58	AGGREGATE PANELS,FASCIA,SOFFIT-REPAIRS	2007	24,910	906	27.5	906		3,284	58
59	INSTALLATION OF AN ANSUL KITCHEN SYSTEM	2007	8,012	291	27.5	291		982	59
60	INSTALL TWO NEW 10 TON ROOFTOP UNITS	2007	23,380	850	27.5	850		2,585	60
61	REPLACE TRANE HEAT EXCHANGER FOR ROOFTOP UNI	2008	3,925	143	27.5	143		304	61
62	FURNISH AND INSTALLED FOUR DAMPERS	2009	5,340	194	27.5	194		315	62
63	MOUNTING 18 CLOSERS, INSTALL NEW DOOR STOP	2009	4,700	171	27.5	171		300	63
64	INSTALL DOORS & HARDWARE IN WINGS 500,600,700,800	2010	9,015	101	27.5	101		101	64
65	ELEVATOR-INSTALL 4 NEW GUIDE SHOE ASSEMBLIES	2010	3,900	30	27.5	30		30	65
66	REPLACE DEFECTIVE CIRCUIT BREAKERS	2010	6,800	51	27.5	51		51	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,181,758	$ 329,332		$ 332,018	$ 2,686	$ 2,484,013	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: 01/01/2010 Ending: 12/31/2010

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	$ 343,843	$ 2,886	$ 34,380	$ 31,494	3-15	$ 312,887	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	334,960					334,960	73
74	RELATED PARTY SL DEPRECIATION		3,517	3,517				74
75	TOTALS	$ 678,803	$ 6,403	$ 37,897	$ 31,494		$ 647,847	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,910,561	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 335,735	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 369,915	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 34,180	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,131,860	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.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: ____ *

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.		$

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: $ 9,690 Description: COPY MACHINE - $7,458 AND PUBLIC STORAGE - $2,232
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2009 FORD XL VAN	$ 690.00	$ 8,280	17
18	FACILITY	2007 FORD F150	595.00	7,159	18
19	PAINTERS			1,854	19
20					20
21	TOTAL		$ #######	$ 17,293	21

* 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.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number LAKE PARK CENTER

STATE OF ILLINOIS
0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	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			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts							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	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.

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,481,567	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	102,897		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	129,847		6
7	Other Prepaid Expenses	56,763		7
8	Accounts Receivable (owners or related parties)	128,752		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,899,826	$	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)	(1,009,082)		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): Amort of Defer Loan Costs	(50,461)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 459,856	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,359,682	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 152,465	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,082		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,675		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)**	$ 315,222	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,913,443		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)**	$ 4,913,443	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,228,665	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,868,983)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,359,682	$	48

***(See instructions.)**

Facility Name & ID Number LAKE PARK CENTER **#** 0027052 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,871,067)	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)**	$ (2,871,068)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,286,210	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	(1,284,125)	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)**	$ 2,085	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)**	$ (2,868,983)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,468,166	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,468,166	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***	86,143	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 86,143	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)**	$ 8,554,309	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,261,757	31
32	Health Care	2,616,448	32
33	General Administration	1,837,748	33
	B. Capital Expense		
34	Ownership	1,393,925	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)***	$ 7,224,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,329,456	41
42	**Income Taxes**	(43,246)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,286,210	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: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 72,291	$ 34.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,691	21,195	608,110	28.69	3
4	Licensed Practical Nurses	12,222	12,925	337,379	26.10	4
5	CNAs & Orderlies	72,110	75,770	919,883	12.14	5
6	CNA Trainees					6
7	Licensed Therapist	4,175	4,348	52,863	12.16	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,384	11,147	116,622	10.46	10
11	Social Service Workers	20,141	20,381	287,389	14.10	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	80,425	38.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,943	19,496	203,571	10.44	15
16	Dishwashers					16
17	Maintenance Workers	8,036	8,260	134,151	16.24	17
18	Housekeepers	15,732	16,460	166,417	10.11	18
19	Laundry	9,649	10,409	103,250	9.92	19
20	Administrator	2,080	2,080	109,973	52.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,669	18,592	244,069	13.13	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 C: Quality Assurance	2,080	2,080	69,871	33.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,072	227,303	$ 3,506,264 *	$ 15.43	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,614	1-3	35
36	Medical Director	Monthly	30,204	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	10,080	10-3	39
40	Physical Therapy Consultant		0	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	5	299	11-3	44
45	Social Service Consultant	55	3,156	12-3	45
46	Other(specify)			10-3	46
47	Psychiatric	Monthly	6,559	10-3	47
48	Dental	Monthly	4,500	10-3	48
49	TOTAL (lines 35 - 48)	60	$ 63,412		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRIAN LIVINGS	ADMINISTRATOR	0	$ 109,973
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,973

B. Administrative - Other

Description		Amount
EMI ENTERPRISES	MANAGEMENT FEES	$ 469,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 469,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 4,068
WESTMONT	DATA PROCESSING	3,000
LTC SOLUTIONS	DATA PROCESSING	1,800
MAXXSOURCE	DATA PROCESSING	936
HDSI	DATA PROCESSING	2,143
KBKB	ACCOUNTING	15,900
PERSONNEL PLANNERS	U.C. CONSULTANT	620
THE PRIVATE BANK	LEGAL FEES	274
HUSCH BLACKWELL	LEGAL FEES	3,375
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 32,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,878
Unemployment Compensation Insurance	14,083
FICA Taxes	256,318
Employee Health Insurance	144,537
Employee Meals	12,045
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,379
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	38,042
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 537,282

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	840
(Indicate # of checks performed 21)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	12,987
MARKETING/ADV/PROMO	227
LICENSES/DUES/SUBSCRIPTIONS	946
MGMT CO ALLOC	3,363
TRUST/FRANCHISE/CONTRIB/ETC	(12,987)
Less: Public Relations Expense	(0)
Non-allowable advertising	(227)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,149

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	2,510
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,510

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7							N/A						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LAKE PARK CENTER **#** 0027052 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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. **ALLIENCE FOR LIVING $ 12,600**

(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. $ 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. $ **12,045** 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.