Facility Name & ID Number LAKE PARK CENTER #0027052 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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			21,825	21,825		21,825	327,838	349,663			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			354,842	354,842		354,842	161,836	516,678			32
33	Real Estate Taxes							174,187	174,187			33
34	Rent-Facility & Grounds			977,550	977,550		977,550	(977,550)				34
35	Rent-Equipment & Vehicles			29,752	29,752		29,752	4,420	34,172			35
36	Other (specify):* **OFFICE RENT**			16,980	16,980		16,980	30,762	47,742			36
37	**TOTAL Ownership**			1,400,949	1,400,949		1,400,949	(278,507)	1,122,442			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)**	3,586,550	524,934	3,037,121	7,148,605		7,148,605	(555,761)	6,592,844			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: 01/01/2011 Ending: 12/31/2011

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	19,642	30		9
10	Interest and Other Investment Income	(26,608)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(730)	2		13
14	Non-Care Related Interest	(344,320)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,000)	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		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(10,000)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (363,016)		$	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)	(192,745)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (192,745)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (555,761)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						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: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ -10,000	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,000)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(730)	0	0	0	0	0	0	0	0	0	0	(730)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	446	0	0	0	0	0	0	0	0	0	446	5
6	Maintenance	0	1,143	3,394	3,528	0	0	0	0	0	0	0	8,065	6
7	Other (specify):*	0	0	85	0	0	0	0	0	0	0	0	85	7
8	**TOTAL General Services**	(730)	1,589	3,479	3,528	0	0	0	0	0	0	0	7,866	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	(10,000)	(247,473)	0	0	0	0	0	0	0	(257,473)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	85	8,005	565	0	0	0	0	0	0	0	8,655	19
20	Fees, Subscriptions & Promotions	(1,000)	46	3,052	0	0	0	0	0	0	0	0	2,098	20
21	Clerical & General Office Expenses	(10,000)	0	(64,078)	7,598	0	0	0	0	0	0	0	(66,480)	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	10	0	0	0	0	0	0	0	0	10	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	1,161	205	0	0	0	0	0	0	0	1,366	25
26	Insurance-Prop.Liab.Malpractice	0	109	218	12,916	0	0	0	0	0	0	0	13,243	26
27	Other (specify):*	0	0	5,246	8,215	0	0	0	0	0	0	0	13,461	27
28	**TOTAL General Administration**	(11,000)	240	(56,386)	(217,974)	0	0	0	0	0	0	0	(285,120)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,730)	1,829	(52,907)	(214,446)	0	0	0	0	0	0	0	(277,254)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	19,642	1,471	134	306,591	0	0	0	0	0	0	0	327,838	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(370,928)	2,489	0	530,275	0	0	0	0	0	0	0	161,836	32
33	Real Estate Taxes	0	2,406	0	171,781	0	0	0	0	0	0	0	174,187	33
34	Rent-Facility & Grounds	0	0	0	(977,550)	0	0	0	0	0	0	0	(977,550)	34
35	Rent-Equipment & Vehicles	0	734	3,213	473	0	0	0	0	0	0	0	4,420	35
36	Other (specify):*	0	(16,980)	0	47,742	0	0	0	0	0	0	0	30,762	36
37	**TOTAL Ownership**	(351,286)	(9,880)	3,347	79,312	0	0	0	0	0	0	0	(278,507)	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)**	(363,016)	(8,051)	(49,560)	(135,134)	0	0	0	0	0	0	0	(555,761)	45

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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
				DA WESTMONT	LINCOLNWOOD	MGMT CONSULT

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	$ 16,980	IME REALTY CORP.		$	$ (16,980)	1
2	V	5	UTILITIES		" " "		446	446	2
3	V	6	REPAIRS/MAINT		" " "		1,143	1,143	3
4	V	19	ACCOUNTING FEES		" " "		85	85	4
5	V	20	LICENSES & PERMITS		" " "		46	46	5
6	V	26	INSURANCE		" " "		109	109	6
7	V	30	DEPRECIATION (SL)		" " "		1,471	1,471	7
8	V	32	INTEREST		" " "		2,489	2,489	8
9	V	33	RE TAX		" " "		2,406	2,406	9
10	V	35	STORAGE FEES		" " "		734	734	10
11	V				" " "				11
12	V				" " "				12
13	V				" " "				13
14	Total			$ 16,980			$ 8,929	$ * (8,051)	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: 01/01/2011 Ending: 12/31/2011

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	$ 97,000	EKS MANAGEMENT CO.		$	$ (97,000)	15
16	V	6	PAINTERS SALARIES		" " "		3,394	3,394	16
17	V	7	SCAVENGER		" " "		85	85	17
18	V	17	CFO SALARY-A.WEINFELD		" " "		10,025	10,025	18
19	V	19	PROFESSIONAL FEES		" " "		7,671	7,671	19
20	V	20	WANT ADS/BACKGR CKS		" " "		3,052	3,052	20
21	V	21	TOTAL OFFICE		" " "		32,922	32,922	21
22	V	23	SEMINAR		" " "		10	10	22
23	V	25	TRANSPORTATION		" " "		1,161	1,161	23
24	V	26	INSURANCE		" " "		218	218	24
25	V	27	EMPLOYEE BENEFITS		" " "		5,246	5,246	25
26	V	30	DEPRECIATION (SL)		" " "		134	134	26
27	V	35	EQUIPMENT RENT		" " "		3,213	3,213	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	17	MANAGEMENT FEES	80,000	DA WESTMONT			(80,000)	33
34	V	19	ACCOUNTING FEES		" " "		334	334	34
35	V	17	ADMIN CONSULTANT-S.HOLT		" " "		15,092	15,092	35
36	V	17	ADMIN CONSULTANT-A.R.M.		" " "		44,883	44,883	36
37	V								37
38	V								38
39	Total			$ 177,000			$ 127,440	$ * (49,560)	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: 01/01/2011 Ending: 12/31/2011

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	$ 282,000	EMI ENTERPRISES INC.		$	$ (282,000)	15
16	V	6	DRIVERS SALARIES		" " "		3,528	3,528	16
17	V	17	M.ESFORMES, OFFICER		" " "		17,002	17,002	17
18	V	17	M.ROSEN-REGIONAL DIRECTOR		" " "		523	523	18
19	V	17	P.ESFORMES-MGT CONSULTANT		" " "		17,002	17,002	19
20	V	19	ACCOUNTING		" " "		565	565	20
21	V	21	TOTAL OFFICE		" " "		7,598	7,598	21
22	V	25	TRANSPORTATION		" " "		205	205	22
23	V	26	INSURANCE		" " "		1,119	1,119	23
24	V	27	EMPLOYEE BENEFITS		" " "		8,215	8,215	24
25	V	35	AUTO LEASE		" " "		473	473	25
26	V								26
27	V								27
28	V	34	RENT	977,550	WAUKEGAN TERRACE PROPERTIES LLC			(977,550)	28
29	V	33	REAL ESTATE TAX		" " " "		171,781	171,781	29
30	V	30	DEPRECIATION (SL)		" " " "		306,591	306,591	30
31	V	32	INTEREST		" " " "		524,304	524,304	31
32	V	32	AMORT LOAN COSTS		" " " "		5,971	5,971	32
33	V	26	INSURANCE		" " " "		11,797	11,797	33
34	V	36	MIP INSURANCE		" " " "		47,742	47,742	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,259,550			$ 1,124,416	$ * (135,134)	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: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FROM EMI ENTERPRISES:				SEE				$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	79.27	ATTACHED	4	5.00	SALARY	17,002	17.-7	2
3	MICHAEL ROSEN	REGIONAL DIRECTOR		0.00	SCHEDULE			SALARY	523	17-7	3
4	PHILIP ESFORMES	ADMIN CONSULTANT		0.00				CONSULT FEE	17,002	17-7	4
5											5
6	ALLOCATION FROM DA WESTMONT:										6
7	FLORA WEISS (A.R.M. ENTERPRISES)	ADMIN CONSULTANT		3.81		4	7.00	CONSULT FEE	44,883	17-7	7
8											8
9											9
10	ALLOCATION FROM EKS MANAGEMENT:										10
11	AVRUM WEINFELD	CFO	CFO	5.60		4	6.00	SALARY	10,025	17-7	11
12											12
13								TOTAL	$ 89,435		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: 01/01/2011 Ending: 2/31/2011

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	847,662	14	$ 38,929	$ 38,929	73,909	$ 3,394	1
2	7	SCAVENGER	PATIENT DAYS	847,662	14	971		73,909	85	2
3	17	CFO SALARY-A.WEINFELD	PATIENT DAYS	847,662	14	114,971	114,971	73,909	10,025	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	847,662	14	87,982	76,534	73,909	7,671	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	847,662	14	35,000		73,909	3,052	5
6	21	TOTAL OFFICE	PATIENT DAYS	847,662	14	377,586	282,348	73,909	32,922	6
7	23	SEMINAR	PATIENT DAYS	847,662	14	115		73,909	10	7
8	25	TRANSPORTATION	PATIENT DAYS	847,662	14	13,315		73,909	1,161	8
9	26	INSURANCE	PATIENT DAYS	847,662	14	2,501		73,909	218	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	60,163		73,909	5,246	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	847,662	14	1,536		73,909	134	11
12	35	EQUIPMENT RENT	PATIENT DAYS	847,662	14	36,848		73,909	3,213	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					$ 769,917	$ 512,782		$ 67,131	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	195,459	14	$ 5,131	$	16,980	$ 446	1
2	6	REPAIRS/MAINT	INCOME	195,459	14	13,157		16,980	1,143	2
3	19	ACCOUNTING FEES	INCOME	195,459	14	973		16,980	85	3
4	20	LICENSES & PERMITS	INCOME	195,459	14	526		16,980	46	4
5	26	INSURANCE	INCOME	195,459	14	1,254		16,980	109	5
6	30	DEPRECIATION (SL)	INCOME	195,459	14	16,930		16,980	1,471	6
7	32	INTEREST	INCOME	195,459	14	28,650		16,980	2,489	7
8	33	RE TAX	INCOME	195,459	14	27,693		16,980	2,406	8
9	35	STORAGE FEES	INCOME	195,459	14	8,451		16,980	734	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					$ 102,765	$		$ 8,929	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	6	DRIVERS SALARIES	PATIENT DAYS	847,662	14	$ 40,460	$ 40,460	73,909	$ 3,528	1
2	17	M.ESFORMES, OFFICER	PATIENT DAYS	847,662	14	195,000	195,000	73,909	17,002	2
3	17	M.ROSEN-REGIONAL DIRECTOR	PATIENT DAYS	847,662	14	6,000	6,000	73,909	523	3
4	17	P.ESFORMES-MGT CONSULTANT	PATIENT DAYS	847,662	14	195,000		73,909	17,002	4
5	19	ACCOUNTING	PATIENT DAYS	847,662	14	6,480		73,909	565	5
6	21	TOTAL OFFICE	PATIENT DAYS	847,662	14	87,144	58,016	73,909	7,598	6
7	25	TRANSPORTATION	PATIENT DAYS	847,662	14	2,349		73,909	205	7
8	26	INSURANCE	PATIENT DAYS	847,662	14	12,837		73,909	1,119	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	94,218		73,909	8,215	9
10	35	AUTO LEASE	PATIENT DAYS	847,662	14	5,423		73,909	473	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					$ 644,911	$ 299,476		$ 56,230	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: DA WESTMONT
Street Address: 6865 N LINCOLN
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	19	ACCOUNTING FEES	CENSUS DAYS	91,323	3	$ 2,475	$	12,308	$ 334	1
2	17	ADMIN CONSULTANT-S.HOLT	CENSUS DAYS	91,323	3	111,983		12,308	15,092	2
3	17	ADMIN CONSULTANT-A.R.M.	CENSUS DAYS	91,323	3	333,025		12,308	44,883	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	TOTALS					$ 447,483	$		$ 60,309	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	9,414,976	04/39	5.1000	524,304	2
3	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			196,243	149,966			5,971	3
4												4
5												5
	Working Capital											
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	01/08	1,215,000	1,334,000		PRIME+	10,522	6
7												7
8	IME REALTY ALLOCATIONS										2,489	8
9	TOTAL Facility Related				$75,439.10		$ 11,735,843	$ 10,898,942			$ 543,286	9
	B. Non-Facility Related*											
10	THE PRIVATE BANK		X	LOAN	DEMAND	01/15/08	5,155,000	4,424,789	01/31/13	PRIME+	283,078	10
11	M. ESFORMES		X	LOAN	$5,750.00	07/01/10	1,000,000	962,829	01/01/34	4.5000	43,942	11
12	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		86,500	18,743			17,300	12
13												13
14	TOTAL Non-Facility Related				$5,750.00		$ 6,241,500	$ 5,406,361			$ 344,320	14
15	TOTALS (line 9+line14)						$ 17,977,343	$ 16,305,303			$ 887,606	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 47,742 **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:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 147,550	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.)		$ 157,306	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,756	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 162,025	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.		$ 171,781	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	130,420	8
	2007	130,941	9
	2008	138,204	10
	2009	143,252	11
	2010	157,306	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-400-032	NURSING HOME	$ 157,305.97	$ 157,305.97
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 157,305.97	$ 157,305.97

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 01/01/2011 Ending: 12/31/2011

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. [X] (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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 2,431,095	4
5											5
6											6
7											7
8	IME ALLOCATION					1,413		1,413			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		44,853	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		39,989	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		13,298	13
14	PARKING LOTS			1993	19,440		15			19,440	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	46		926	15
16	NURSE STATION			1993	7,800	200	31.5	200		4,022	16
17	ELEVATOR			1994	22,300	572	39	572		9,986	17
18	CUBICLE CURTAINS			1994	843	22	39	22		391	18
19	PARKING LOTS LIGHTS			1995	8,677		15			8,677	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		4,115	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		2,990	21
22	TILE			1996	20,387	522	39	522		7,984	22
23	WEATHER-ROOFTOP			1997	6,408	164	39	164		2,303	23
24	METAL DOORS & AIR CONDITION			1998	11,993	308	39	308		4,273	24
25	TWO SHOWERS			1998	2,720	70	39	70		965	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		3,378	26
27	CABINNERY-ADM., BOOKKEPING, DON			1998	33,000	846	39	846		11,245	27
28	WATER HEATER			1998	4,639	119	39	119		1,562	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		1,468	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		8,242	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE			1999	18,547	476	39	476		5,732	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK			1999	8,640	222	39	222		2,692	32
33	FIRE DAMPERS			2000	8,070	293	20	293		3,382	33
34	FENCE			2000	6,810	409	15	409		5,164	34
35	CUBICLE CURTAINS			2001	14,018		20	701	701	7,711	35
36	ROOF MAINTENANCE & FLASHING REPAIR			2001	6,950	253	27.5	253		2,783	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 1,122	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895		20	2,245	2,245	24,695	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		11,528	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		5,159	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		11,662	41
42	INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		5,232	42
43	INSTALL STEEL ROLLING DOOR	2006	2,878	105	27.5	105		617	43
44	REPLACE HOT WATER HEATER	2006	8,476	308	27.5	308		1,733	44
45	INSTALL SWING GATES WITH POSTS	2006	1,825	122	15	122		732	45
46	SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	992	15	992		5,952	46
47	INSTALL DOORS	2006	171,211	6,226	27.5	6,226		31,389	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		9,734	55
56	INSTALL NEW DURO-LAST ROOF SYSTEM	2007	121,800	4,429	27.5	4,429		19,981	56
57	INSTALLATION OF AIR CLEANING EQUIPMENT	2007	8,736	318	27.5	318		1,524	57
58	AGGREGATE PANELS,FASCIA,SOFFIT-REPAIRS	2007	24,910	906	27.5	906		4,190	58
59	INSTALLATION OF AN ANSUL KITCHEN SYSTEM	2007	8,012	291	27.5	291		1,273	59
60	INSTALL TWO NEW 10 TON ROOFTOP UNITS	2007	23,380	850	27.5	850		3,435	60
61	REPLACE TRANE HEAT EXCHANGER FOR ROOFTOP UNI	2008	3,925	143	27.5	143		447	61
62	FURNISH AND INSTALLED FOUR DAMPERS	2009	5,340	194	27.5	194		509	62
63	MOUNTING 18 CLOSERS, INSTALL NEW DOOR STOP	2009	4,700	171	27.5	171		471	63
64	INSTALL DOORS & HARDWARE IN WINGS 500,600,700,800	2010	9,015	328	27.5	328		429	64
65	ELEVATOR-INSTALL 4 NEW GUIDE SHOE ASSEMBLIES	2010	3,900	142	27.5	142		172	65
66	REPLACE DEFECTIVE CIRCUIT BREAKERS	2010	6,800	247	27.5	247		298	66
67	INSTALL FIRE/SMOKE DAMPERS	2011	2,790	80	27.5	80		80	67
68	INSTALL NEW HYDRAUTIC ELEVATOR SOFT START	2011	2,200	50	27.5	50		50	68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,186,748	$ 329,654		$ 332,340	$ 2,686	$ 2,814,940	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 171,310	$ 175	$ 17,131	$ 16,956	3-15	$ 126,983	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	507,493					507,493	73
74	RELATED PARTY SL DEPRECIATION		192	192				74
75	TOTALS	$ 678,803	$ 367	$ 17,323	$ 16,956		$ 634,476	75

D. Vehicle Costs. (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)	$ 10,915,551	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 330,021	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 349,663	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 19,642	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,449,416	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: 01/01/2011 Ending: 12/31/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 9,700 Description: COPY MACHINE-$7,312 AND PUBLIC STORAGE-$2,388
(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	MAINTENANCE	2010 FORD F150	599.00	7,233	18
19	PAINTERS			4,539	19
20					20
21	TOTAL		$ #######	$ 20,052	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: 01/01/2011 Ending: 12/31/2011

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: 01/01/2011 Ending: 12/31/2011

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							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			N/A				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: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ (142)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,160,697		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,682		6
7	Other Prepaid Expenses	6,277		7
8	Accounts Receivable (owners or related parties)	131,694		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,405,208	$	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)	(1,030,907)		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	(67,757)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 420,735	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,825,943	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 243,178	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,334,000		29
30	Accrued Salaries Payable	156,489		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,270		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,750,937	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,705,701		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)**	$ 4,705,701	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,456,638	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,630,695)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,825,943	$	48

*(See instructions.)

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,868,983)	1
2	Restatements (describe):		2
3	ROUNDING	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,868,977)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,303,409	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	(1,065,127)	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)**	$ 238,282	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)**	$ (2,630,695)	24 *

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 8,449,340	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,449,340	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***	26,608	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,608	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)**	$ 8,475,948	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,329,560	31
32	Health Care	2,693,443	32
33	General Administration	1,609,678	33
	B. Capital Expense		
34	Ownership	1,400,949	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)***	$ 7,148,605	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,327,343	41
42	**Income Taxes**	(23,934)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,303,409	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: 01/01/2011 Ending: 12/31/2011

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	2,135	2,135	$ 76,448	$ 35.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,100	20,646	599,672	29.05	3
4	Licensed Practical Nurses	12,716	13,524	352,009	26.03	4
5	CNAs & Orderlies	74,607	78,468	960,195	12.24	5
6	CNA Trainees					6
7	Licensed Therapist	4,988	5,176	75,369	14.56	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,740	9,390	97,267	10.36	10
11	Social Service Workers	20,993	21,176	298,315	14.09	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	81,832	39.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,286	19,033	204,626	10.75	15
16	Dishwashers					16
17	Maintenance Workers	7,263	7,407	138,235	18.66	17
18	Housekeepers	15,172	16,125	167,682	10.40	18
19	Laundry	10,929	11,642	115,003	9.88	19
20	Administrator	2,080	2,080	112,621	54.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,708	18,482	249,049	13.48	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	1,820	1,820	58,227	31.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	217,617	229,184	$ 3,586,550 *	$ 15.65	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 fee	$ 9,228	1-3	35
36	Medical Director	Monthly fee	30,672	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly fee	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		0	11-3	44
45	Social Service Consultant	94	5,380	12-3	45
46	Other(specify) Dental	Monthly fee	4,500	10-3	46
47	Psychiatric	Monthly fee	6,958	10-3	47
48	Psycho-Social	Monthly fee	500	10-3	48
49	TOTAL (lines 35 - 48)	94	$ 67,318		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRIAN LIVINGS	ADMINISTRATOR	0	$ 112,621
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,621

B. Administrative - Other

Description		Amount
EMI ENTERPRISES	MANAGEMENT FEES	$ 282,000
DA WESTMONT	MANAGEMENT FEES	80,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 362,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 4,043
WESTMONT NURSING	DATA PROCESSING	3,000
LTC SOLUTIONS	DATA PROCESSING	1,500
MAXXSOURCE	DATA PROCESSING	961
HDSI	DATA PROCESSING	2,271
KBKB	ACCOUNTING	18,000
ALLEN LEFKOVITZ	LEGAL FEES	1,668
ROBBINS,SOLOMON & PRATT	LEGAL FEES	813
JAMES MAINZER	TAX CONSULTANT	3,400
PERSONNEL PLANNERS	U.C. CONSULTANT	742
SEFARTH AND SHAW	LEGAL FEES	55
WALTON MGMT	TAX CONSULTANT	45
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 36,498

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,606
Unemployment Compensation Insurance	16,393
FICA Taxes	268,912
Employee Health Insurance	158,341
Employee Meals	11,589
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	955
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	50,704
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 600,500

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	950
(Indicate # of checks performed 13)	
Patient Background Checks 13	1,220
TRUST/FRANCHISE/CONTRIB/ETC	1,000
MARKETING/ADV/PROMO	0
LICENSES/DUES/SUBSCRIPTIONS	8,887
MGMT CO ALLOC	3,098
TRUST/FRANCHISE/CONTRIB/ETC	(1,000)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,155

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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													
8						N/A							
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 $7,560**

(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. $ **11,589** 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.