FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

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: SANFORD BOKOR **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 01/01/2014 to 12/31/2014 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) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2014 Ending: 12/31/2014

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	210	Intermediate (ICF)	210	76,650	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					8
9	SNF/PED					9
10	ICF	63,634	1,310	2,245	67,189	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,634	1,310	2,245	67,189	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.66%

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 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	333,513	20,335	11,307	365,155		365,155		365,155			1
2	Food Purchase		283,479		283,479	(14,564)	268,915	(1,353)	267,562			2
3	Housekeeping	152,818	40,117		192,935		192,935		192,935			3
4	Laundry	97,446	10,949	1,471	109,866		109,866		109,866			4
5	Heat and Other Utilities			179,461	179,461		179,461	621	180,082			5
6	Maintenance	54,343	16,929	35,672	106,944		106,944	1,609	108,553			6
7	Other (specify):*			20,101	20,101		20,101	174	20,275			7
8	TOTAL General Services	638,120	371,809	248,012	1,257,941	(14,564)	1,243,377	1,051	1,244,428			8
	B. Health Care and Programs											
9	Medical Director			31,200	31,200		31,200		31,200			9
10	Nursing and Medical Records	2,056,231	130,159	22,100	2,208,490		2,208,490		2,208,490			10
10a	Therapy	31,838			31,838		31,838		31,838			10a
11	Activities	112,217	1,335	4,559	118,111		118,111		118,111			11
12	Social Services	331,332		1,617	332,949		332,949		332,949			12
13	CNA Training											13
14	Program Transportation			52	52		52		52			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,531,618	131,494	59,528	2,722,640		2,722,640		2,722,640			16
	C. General Administration											
17	Administrative	114,707		360,000	474,707		474,707	(240,796)	233,911			17
18	Directors Fees											18
19	Professional Services			62,050	62,050		62,050	16,034	78,084			19
20	Dues, Fees, Subscriptions & Promotions			53,537	53,537		53,537	(29,712)	23,825			20
21	Clerical & General Office Expenses	204,474	29,890	40,062	274,426		274,426	19,657	294,083			21
22	Employee Benefits & Payroll Taxes			602,435	602,435	14,564	616,999		616,999			22
23	Inservice Training & Education			4,165	4,165		4,165		4,165			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,160	4,160		4,160	203	4,363			25
26	Insurance-Prop.Liab.Malpractice			52,912	52,912		52,912	29,748	82,660			26
27	Other (specify):*			92,000	92,000		92,000	(80,821)	11,179			27
28	TOTAL General Administration	319,181	29,890	1,271,321	1,620,392	14,564	1,634,956	(285,687)	1,349,269			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,488,919	533,193	1,578,861	5,600,973		5,600,973	(284,636)	5,316,337			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: 01/01/2014** **Ending: 12/31/2014**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,257	
	REPAIRS & MAINTENANCE		2,050	
				11,307
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,471	
				1,471
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		58,070	
	ELECTRICITY		60,381	
	WATER		60,146	
	CABLE TV - LOBBY		864	
				179,461
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,960	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		12,455	
	ELEVATOR MAINTENANCE & REPAIR		8,307	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,025	
	FIRE SERVICE		5,925	
				35,672
7	**OTHER**			
	SCAVENGER		19,389	
	SECURITY SERVICE		712	
				20,101
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	31,200	31,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		1,117	
	PURCHASED SERVICES		193	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	13,194	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	396	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		7,200	
				22,100
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	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		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,559	
				4,559
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,617	
	SOCIAL WORKER	XVIII B 45-2	0	
				1,617
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKE PARK CENTER **#0027052** **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		52	
				52
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	360,000	360,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,440	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	49,610	
				62,050
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	15,527	
	LICENSES & PERMITS	XIX F	3,162	
	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	31,113	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,845	
	PATIENT BACKGROUND CHECKS	XIX F	890	
				53,537
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		80	
	EQUIPMENT REPAIR & MAINTENANCE		828	
	OUTSIDE CLERICAL SERVICES		24,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	28	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,126	
	MESSENGER SERVICE		0	
				40,062

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	260,573	
	UNEMPLOYMENT COMPENSATION	XIX D	15,283	
	WORKERS COMPENSATION INSURANC	XIX D	86,865	
	HOSPITALIZATION INSURANCE	XIX D	161,875	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,700	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	76,139	
	CHICAGO HEAD TAX	XIX D	0	
				602,435
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,165	
				4,165
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,160	
				4,160
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		52,912	
				52,912
27	**OTHER**			
	BAD DEBTS	VI 24	92,000	
				92,000

GRAND TOTAL COLUMN 3 OTHER **1,578,861**

LAKE PARK CENTER
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	283,479
LESS SALES TAX	(1,353)
NET FOOD	282,126
TOTAL PATIENT CENSUS	67,189
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	201,567
ADD # EMPLOYEE MEALS/DAY	30
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	201,567
ADD EMPLOYEE MEALS	10,950
TOTAL MEALS/YEAR	212,517
NET FOOD	282,126
DIVIDE TOTAL MEALS/YEAR	212,517
COST PER MEAL	1.33
TIMES EMPLOYEE MEALS	10,950
EMPLOYEE MEAL RECLASSIFICATION	**14,564**

Facility Name & ID Number LAKE PARK CENTER #0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			24,230	24,230		24,230	324,786	349,016			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			175,038	175,038		175,038	68,183	243,221			32
33	Real Estate Taxes							108,390	108,390			33
34	Rent-Facility & Grounds			800,892	800,892		800,892	(800,892)				34
35	Rent-Equipment & Vehicles			18,121	18,121		18,121	2,559	20,680			35
36	Other (specify):* RENT OFFICE			17,400	17,400		17,400	25,143	42,543			36
37	**TOTAL Ownership**			1,035,681	1,035,681		1,035,681	(271,831)	763,850			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											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,488,919	533,193	2,614,542	6,636,654		6,636,654	(556,467)	6,080,187			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: 01/01/2014 Ending: 12/31/2014

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 Reference	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	11,796	30		9
10	Interest and Other Investment Income	(25,611)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,353)	2		13
14	Non-Care Related Interest	(153,618)	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	(28)	21		18
19	Entertainment		20		19
20	Contributions	(31,113)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(92,000)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (294,427)		$	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)	(262,040)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (262,040)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (556,467)		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: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(1,353)	0	0	0	0	0	0	0	0	0	0	(1,353)	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	621	0	0	0	0	0	0	0	0	0	621	5
6	Maintenance	0	1,466	143	0	0	0	0	0	0	0	0	1,609	6
7	Other (specify):*	0	0	174	0	0	0	0	0	0	0	0	174	7
8	**TOTAL General Services**	(1,353)	2,087	317	0	0	0	0	0	0	0	0	1,051	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	(240,796)	0	0	0	0	0	0	0	0	(240,796)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,500)	96	1,883	16,555	0	0	0	0	0	0	0	16,034	19
20	Fees, Subscriptions & Promotions	(31,113)	28	1,373	0	0	0	0	0	0	0	0	(29,712)	20
21	Clerical & General Office Expenses	(28)	29	19,656	0	0	0	0	0	0	0	0	19,657	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	203	0	0	0	0	0	0	0	0	203	25
26	Insurance-Prop.Liab.Malpractice	0	136	183	29,429	0	0	0	0	0	0	0	29,748	26
27	Other (specify):*	(92,000)	0	11,179	0	0	0	0	0	0	0	0	(80,821)	27
28	**TOTAL General Administration**	(125,641)	289	(206,319)	45,984	0	0	0	0	0	0	0	(285,687)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(126,994)	2,376	(206,002)	45,984	0	0	0	0	0	0	0	(284,636)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER **#** 0027052 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	11,796	1,663	134	311,193	0	0	0	0	0	0	0	324,786	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(179,229)	1,303	0	246,109	0	0	0	0	0	0	0	68,183	32
33	Real Estate Taxes	0	3,378	0	105,012	0	0	0	0	0	0	0	108,390	33
34	Rent-Facility & Grounds	0	0	0	(800,892)	0	0	0	0	0	0	0	(800,892)	34
35	Rent-Equipment & Vehicles	0	1,700	859	0	0	0	0	0	0	0	0	2,559	35
36	Other (specify):*	0	(17,400)	0	42,543	0	0	0	0	0	0	0	25,143	36
37	TOTAL Ownership	(167,433)	(9,356)	993	(96,035)	0	0	0	0	0	0	0	(271,831)	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)	(294,427)	(6,980)	(205,009)	(50,051)	0	0	0	0	0	0	0	(556,467)	45

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
SEE PAGE 6-SUPPLEMENTAL		SEE PAGE 6-SUPPLEMENTAL		SEE PAGE 6-SUPPLEMENTAL		

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	$ 17,400	IME REALTY CORP.		$	$ (17,400)	1
2	V	5	UTILITIES				621	621	2
3	V	6	REPAIRS/MAINT				1,466	1,466	3
4	V	19	ACCOUNTING FEES				96	96	4
5	V	20	LICENSES & PERMITS				28	28	5
6	V	21	OFFICE EXPENSE				29	29	6
7	V	26	INSURANCE				136	136	7
8	V	30	DEPRECIATION (SL)				1,663	1,663	8
9	V	32	INTEREST				1,303	1,303	9
10	V	33	RE TAX				3,378	3,378	10
11	V	35	STORAGE FEES				1,700	1,700	11
12	V								12
13	V								13
14	Total			$ 17,400			$ 10,420	$ * (6,980)	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: 01/01/2014 Ending: 12/31/2014

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	$ 24,000	EKS MANAGEMENT CO.		$	$ (24,000)	15
16	V	6	CLEANING SUPPLIES				143	143	16
17	V	7	SCAVENGER				174	174	17
18	V	17	CFO SALARY-A.WEINFELD				15,657	15,657	18
19	V	19	PROFESSIONAL FEES				851	851	19
20	V	20	WANT ADS/BACKGR CKS				1,373	1,373	20
21	V	21	TOTAL OFFICE				43,656	43,656	21
22	V	25	TRAVEL				203	203	22
23	V	26	INSURANCE				183	183	23
24	V	27	EMPLOYEE BENEFITS				8,280	8,280	24
25	V	30	DEPRECIATION (SL)				134	134	25
26	V	35	EQUIPMENT RENT				859	859	26
27	V								27
28	V								28
29	V								29
30	V	17	MANAGEMENT FEES	360,000	DA WESTMONT			(360,000)	30
31	V	17	OFFICER SALARIES-A. WEINFELD				15,732	15,732	31
32	V	17	OFICER SALARIES-D. WEISS				15,732	15,732	32
33	V	17	ADMIN CONSULTANT-A.R.M.				72,083	72,083	33
34	V	19	ACCOUNTING FEES				1,032	1,032	34
35	V	27	PAYROLL TAXES				2,899	2,899	35
36	V								36
37	V								37
38	V								38
39	Total			$ 384,000			$ 178,991	$ * (205,009)	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: 01/01/2014 Ending: 12/31/2014

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	34	RENT	$ 800,892	WAUKEGAN TERRACE PROPERTIES LLC		$	$ (800,892)	15
16	V	33	REAL ESTATE TAX				105,012	105,012	16
17	V	30	DEPRECIATION (SL)				311,193	311,193	17
18	V	32	INTEREST				240,673	240,673	18
19	V	32	AMORT LOAN COSTS				5,436	5,436	19
20	V	26	INSURANCE				29,429	29,429	20
21	V	36	MIP INSURANCE				42,543	42,543	21
22	V	19	PROFESSIONAL FEES				16,555	16,555	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			$ 800,892			$ 750,841	$ * (50,051)	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: 01/01/2014 Ending: 12/31/2014

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	AVRUM WEINFELD	45.24	BRIA OF CAHOKIA	CAHOKIA	EKS MANAGEMENT	LINCOLNWOOD	MANAGEMENT	2
3								3
4	DANIEL WEISS	45.24	BRIA OF FOREST EDGE	CHICAGO	IME REALTY CORP	LINCOLNWOOD	HOME OFFICE	4
5								5
6	FLORA WEISS	3.81	BRIA OF BELLEVILLE	BELLEVILLE	DA WESTMONT	LINCOLNWOOD	MGMT CONSULT	6
7								7
8	D'VORAH WEINFELD	1.43	BRIA OF GENEVA	GENEVA	BRIA HEALTH			8
9					SERVICES, LLC	LINCOLNWOOD	MANAGEMENT	9
10	MIRIAM WEINFELD ROBINSON	2.85	BRIA OF WESTMONT	WESTMONT				10
11					WAUKEGAN			11
12	RIVKA WEISS	1.43	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO	PROPERTIES, LLC	LINCOLNWOOD	REAL ESTATE	12
13				HEIGHTS				13
14								14
15			BRIA OF PALOS HILLS	PALOS HILLS				15
16								16
17			BRIA OF RIVER OAKS	BURNHAM				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: 01/01/2014 Ending: 12/31/2014

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 DA WESTMONT:								$		1
2	FLORA WEISS (A.R.M. ENTERPRISES)										2
3		ADMIN CONSULTANT		3.81	SEE	40	57.14	CONSULT FEE	72,083	17-7	3
4	AVRUM WEINFELD	CFO	CFO	45.24	ATTACHED	15	13.76	SALARIES	15,537	17-7	4
5					SCHEDULE						5
6	DANIEL WEISS		ADMINISTR.	45.24		15	13.04	SALARIES	15,537	17-7	6
7											7
8	ALLOCATION FROM EKS MANAGEMENT:										8
9	AVRUM WEINFELD	CFO	CFO	45.24				SALARIES	15,657	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 118,814		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: 01/01/2014 Ending: 2/31/2014

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	CLEANING SUPPLIES	PATIENT DAYS	293,675		$ 623	$	67,189	$ 143	1
2	7	SCAVENGER	PATIENT DAYS	293,675		759		67,189	174	2
3	17	CFO SALARY-A.WEINFELD	PATIENT DAYS	293,675		68,433	68,433	67,189	15,657	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	293,675		3,720		67,189	851	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	293,675		6,000		67,189	1,373	5
6	21	TOTAL OFFICE	PATIENT DAYS	293,675		190,816	141,933	67,189	43,656	6
7	25	TRAVEL	PATIENT DAYS	293,675		886		67,189	203	7
8	26	INSURANCE	PATIENT DAYS	293,675		802		67,189	183	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	293,675		36,193		67,189	8,280	9
10	30	DEPRECIATION (SL)	PATIENT DAYS	293,675		586		67,189	134	10
11	35	EQUIPMENT RENT	PATIENT DAYS	293,675		3,753		67,189	859	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					$ 312,571	$ 210,366		$ 71,513	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	131,400	6	$ 4,687	$	17,400	$ 621	1
2	6	REPAIRS/MAINT	INCOME	131,400	6	11,070		17,400	1,466	2
3	19	ACCOUNTING FEES	INCOME	131,400	6	724		17,400	96	3
4	20	LICENSES & PERMITS	INCOME	131,400	6	210		17,400	28	4
5	21	OFFICE EXPENSE	INCOME	131,400	6	221		17,400	29	5
6	26	INSURANCE	INCOME	131,400	6	1,026		17,400	136	6
7	30	DEPRECIATION (SL)	INCOME	131,400	6	12,550		17,400	1,663	7
8	32	INTEREST	INCOME	131,400	6	9,842		17,400	1,303	8
9	33	RE TAX	INCOME	131,400	6	25,509		17,400	3,378	9
10	35	STORAGE FEES	INCOME	131,400	6	12,837		17,400	1,700	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					$ 78,676	$		$ 10,420	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	17	OFFICER SALARIES-A. WEINFEL	CENSUS DAYS	170,831	3	$ 40,000	$ 40,000	67,189	$ 15,732	1
2	17	OFICER SALARIES-D. WEISS	CENSUS DAYS	170,831	3	40,000	40,000	67,189	15,732	2
3	17	ADMIN CONSULTANT-A.R.M.	CENSUS DAYS	170,831	3	183,275		67,189	72,083	3
4	19	ACCOUNTING FEES	CENSUS DAYS	170,831	3	2,625		67,189	1,032	4
5	27	PAYROLL TAXES	CENSUS DAYS	170,831	3	7,370		67,189	2,899	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					$ 273,270	$ 80,000		$ 107,478	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: WAUKEGAN TERRACE PROPERTIES, LLC						$	$			$	1
2	CAPITAL ONE FINANCE	X		MORTGAGE	$64,511.91	11/29/12	9,657,100	9,134,873	05/01/39	2.6000	240,673	2
3	LOAN COSTS	X		LOAN COSTS	W/O OVER LOAN		308,376	131,231			5,436	3
4												4
5												5
	Working Capital											
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	01/08	1,215,000	198,000		PRIME+	21,420	6
7												7
8	IME REALTY ALLOCATIONS										1,303	8
9	TOTAL Facility Related				$64,511.91		$ 11,180,476	$ 9,464,104			$ 268,832	9
	B. Non-Facility Related*											
10	THE PRIVATE BANK		X	LOAN	$20,833.00	01/15/08	5,155,000	2,218,877		PRIME+	69,327	10
11	M. ESFORMES		X	LOAN	$5,750.00	07?01/10	1,000,000	880,535	01/01/34	4.5000	40,328	11
12	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		86,500					12
13	M. ESFORMES		X	LOAN	$6,000.00	03/01/13	1,500,000	1,449,233	11/01/45	3.0019	43,963	13
14	TOTAL Non-Facility Related				$32,583.00		$ 7,741,500	$ 4,548,645			$ 153,618	14
15	TOTALS (line 9+line14)						$ 18,921,976	$ 14,012,749			$ 422,450	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 42,543 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: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 175,097	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.)		$ 139,359	2
3. Under or (over) accrual (line 2 minus line 1).		$ (35,738)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 140,750	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.		$ 105,012	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	143,252	8
	2010	157,306	9
	2011	142,166	10
	2012	173,364	11
	2013	139,359	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 2013 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE PARK CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027052

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-400-032	NURSING HOME	$ 139,358.90	$ 139,358.90
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 139,358.90	$ 139,358.90

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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? [X] (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? [X] (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: 01/01/2014 Ending: 12/31/2014

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	$	$ 3,023,443	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				48,320	1,601		1,601			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		(1,282)	45,000	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		43,597	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		14,598	13
14	PARKING LOTS			1993	19,440		15			19,440	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	46		1,018	15
16	NURSE STATION			1993	7,800	200	31.5	200		4,422	16
17	ELEVATOR			1994	22,300	572	39	572		11,130	17
18	CUBICLE CURTAINS			1994	843	22	39	22		435	18
19	PARKING LOTS LIGHTS			1995	8,677		15			8,677	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		4,615	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		3,360	21
22	TILE			1996	20,387	522	39	522		9,028	22
23	WEATHER-ROOFTOP			1997	6,408	164	39	164		2,631	23
24	METAL DOORS & AIR CONDITION			1998	11,993	308	39	308		4,889	24
25	TWO SHOWERS			1998	2,720	70	39	70		1,105	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		3,880	26
27	CABINNERY-ADM., BOOKKEPING, DON			1998	33,000	846	39	846		12,937	27
28	WATER HEATER			1998	4,639	119	39	119		1,800	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		1,702	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		9,574	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE			1999	18,547	476	39	476		6,684	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK			1999	8,640	222	39	222		3,136	32
33	FIRE DAMPERS			2000	8,070	293	20	293		3,968	33
34	FENCE			2000	6,810	409	15	409		5,982	34
35	CUBICLE CURTAINS			2001	14,018		20	701	701	9,113	35
36	ROOF MAINTENANCE & FLASHING REPAIR			2001	6,950	253	27.5	253		3,289	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: 01/01/2014 Ending: 12/31/2014

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	$	$ 1,326	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895		20	2,245	2,245	29,185	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		13,624	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		6,097	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		14,218	41
42	INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		6,964	42
43	INSTALL STEEL ROLLING DOOR	2006	2,878	105	27.5	105		827	43
44	REPLACE HOT WATER HEATER	2006	8,476	308	27.5	308		2,349	44
45	INSTALL SWING GATES WITH POSTS	2006	1,825	122	15	122		976	45
46	SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	992	15	992		7,936	46
47	INSTALL DOORS	2006	171,211	6,226	27.5	6,226		43,841	47
48									48
49									49
50	WAUKEGAN TERRACE PROPERTIES,LLC								50
51	INSTALL DOORS - FIRST FLOOR HALLWAY,CORIDOR	2007	62,358	2,268	27.5	2,268		14,270	51
52	INSTALL NEW DURO-LAST ROOF SYSTEM	2007	121,800	4,429	27.5	4,429		28,839	52
53	INSTALLATION OF AIR CLEANING EQUIPMENT	2007	8,736	318	27.5	318		2,160	53
54	AGGREGATE PANELS,FASCIA,SOFFIT-REPAIRS	2007	24,910	906	27.5	906		6,002	54
55	INSTALLATION OF AN ANSUL KITCHEN SYSTEM	2007	8,012	291	27.5	291		1,855	55
56	INSTALL TWO NEW 10 TON ROOFTOP UNITS	2007	23,380	850	27.5	850		5,135	56
57	REPLACE TRANE HEAT EXCHANGER FOR ROOFTOP UNIT	2008	3,925	143	27.5	143		733	57
58	FURNISH AND INSTALLED FOUR DAMPERS	2009	5,340	194	27.5	194		897	58
59	MOUNTING 18 CLOSERS, INSTALL NEW DOOR STOP	2009	4,700	171	27.5	171		813	59
60	INSTALL DOORS & HARDWARE IN WINGS 500,600,700,800	2010	9,015	328	27.5	328		1,085	60
61	ELEVATOR-INSTALL 4 NEW GUIDE SHOE ASSEMBLIES	2010	3,900	142	27.5	142		456	61
62	REPLACE DEFECTIVE CIRCUIT BREAKERS	2010	6,800	247	27.5	247		792	62
63	INSTALL FIRE/SMOKE DAMPERS	2011	2,790	101	27.5	101		282	63
64	INSTALL NEW HYDRAUTIC ELEVATOR SOFT START	2011	2,200	80	27.5	80		210	64
65	SEALCOAT APPR 44,716 SQUARE FEET; ASPHALT 8 AREAS	2012	6,300	229	27.5	229		296	65
66	REPLACEMENT OF ROOF TOP UNITS & HEAT EXCHYANG	2012	25,630	2,241	7	3,662	1,421	3,779	66
67	REPLACE HEAT EXCHANGER 2ND FLOOR ROTUNDA	2013	3,295	120	27.5	120		235	67
68	CLOSERS FOR FIRE DOORS, FRONT DOOR, BATHROOM								68
69	AND CLOSET SPRING HINGES	2013	6,580	239	27.5	239		408	69
70	TOTAL (lines 4 thru 69)		$ 9,276,873	$ 332,722		$ 335,400	$ 2,825	$ 3,478,903	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: 01/01/2014 Ending: 12/31/2014

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	
1	Totals from Page 12A, Carried Forward		$ 9,276,873	$ 332,722		$ 335,400	$ 2,678	$ 3,478,903	1
2	REPLACE TWO OLD RHEEM MODEL WATER HEATER	2014	26,875	692	27.5	692		692	2
3	INSTALLED NEW DURO-LAST ROOF SYSTEM	2014	27,352	705	27.5	705		705	3
4	REPLACEMENT FIRE DOORS	2014	7,865	179	27.5	179		179	4
5	MASONRY AND CONCRETE REPAIR & RESTORATION:								5
6	PATCH UT TO 55 SQUARE FEET OF AGGREGATE PATCHING								6
7	AT VARIOUS LOCATIONS AROUND THE FAÇADE	2014	19,250	146	27.5	146		146	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	TOTAL (lines 1 thru 33)		$ 9,358,215	$ 334,444		$ 337,122	$ 2,678	$ 3,480,625	34

**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: 01/01/2014 Ending: 12/31/2014

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	$ 181,493	$ 2,580	$ 11,698	$ 9,118	3-10	$ 165,273	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	513,439					513,439	73
74	RELATED PARTY SL DEPRECIATION		196	196				74
75	TOTALS	$ 694,932	$ 2,776	$ 11,894	$ 9,118		$ 678,712	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)	$ 11,103,147	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 337,220	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 349,016	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,796	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,159,337	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: 01/01/2014 Ending: 12/31/2014

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 ☒ X NO
16. Rental Amount for movable equipment: $ 9,841 Description: COPY MACHINE-$6,706 AND STORAGE-$3,135
    (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					18
19					19
20					20
21	TOTAL		$ 690.00	$ 8,280	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: 01/01/2014 Ending: 12/31/2014

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 # 0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ (37,030)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,448)	1,339,298		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,559		6
7	Other Prepaid Expenses	4,886		7
8	Accounts Receivable (owners or related parties)	139,874		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,539,587	$	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	694,932		16
17	Accumulated Depreciation (book methods)	(1,108,115)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 340,913	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,880,500	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,040	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	198,000		29
30	Accrued Salaries Payable	37,444		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,000		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)**	$ 370,484	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,874,063		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)**	$ 3,874,063	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,244,547	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,364,047)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,880,500	$	48

*(See instructions.)

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,336,531)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,336,529)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	297,919	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	(325,437)	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)**	$ (27,518)	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)**	$ (2,364,047)	24 *

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,862,954	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,862,954	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***	25,611	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,611	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	W/C INCURANCE AUDIT	54,926	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 54,926	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,943,491	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,257,941	31
32	Health Care	2,722,640	32
33	General Administration	1,620,392	33
	B. Capital Expense		
34	Ownership	1,035,681	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,636,654	40
41	**Income before Income Taxes (line 30 minus line 40)****	306,837	41
42	**Income Taxes**	(8,918)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 297,919	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,432,040	44
45	Private Pay - Net Inpatient Revenue	158,160	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify) VETERAN	272,754	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,862,954	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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: 01/01/2014 Ending: 12/31/2014

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	2,220	2,220	$ 74,918	$ 33.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,206	21,902	614,195	28.04	3
4	Licensed Practical Nurses	13,028	13,656	346,846	25.40	4
5	CNAs & Orderlies	79,203	83,999	1,020,272	12.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,617	1,617	31,838	19.69	8
9	Activity Director					9
10	Activity Assistants	9,983	10,689	112,217	10.50	10
11	Social Service Workers	25,040	25,040	331,332	13.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,038	24,687	333,513	13.51	15
16	Dishwashers					16
17	Maintenance Workers	3,120	3,380	54,343	16.08	17
18	Housekeepers	13,552	14,520	152,818	10.52	18
19	Laundry	8,931	9,697	97,446	10.05	19
20	Administrator	2,160	2,160	114,707	53.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,896	15,849	204,474	12.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,994	229,416	$ 3,488,919 *	$ 15.21	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	M	$ 9,257	1-3	35
36	Medical Director	O	31,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	13,194	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,559	11-3	44
45	Social Service Consultant	E	1,617	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 59,827		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: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROBERT BRYAN LIVINGS	ADMINISTRATOR	0	$ 114,707
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,707

B. Administrative - Other

Description		Amount
DA WESTMONT	MANAGEMENT FEES	$ 360,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 360,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
ALPHA DATA	DATA PROCESSING	4,652
WESTMONT NURSING	DATA PROCESSING	3,000
LTC SOLUTIONS	DATA PROCESSING	1,639
MAXXSOURCE	DATA PROCESSING	836
HDSI	DATA PROCESSING	2,313
KBKB	ACCOUNTING	18,000
PERSONNEL PLANNERS	U.C. CONSULTANT	552
STONE, MCGUIRE & SIEGEL	LEGAL FEES	12,931
WALTON MGMT SERVVICE	WOTC CREDITS	4,436
SKIDELSKY & ASSOCIATES	LEGAL FEES	13,691
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 62,050

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 86,865
Unemployment Compensation Insurance		15,283
FICA Taxes		260,573
Employee Health Insurance		161,875
Employee Meals		14,564
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,700
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		76,139
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 616,999

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	$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check	2,845
(Indicate # of checks performed 51)	
Patient Background Checks 6	890
TRUST/FRANCHISE/CONTRIB/ETC	31,113
MARKETING/ADV/PROMO	0
LICENSES/DUES/SUBSCRIPTIONS	16,699
MGMT CO ALLOC	1,401
TRUST/FRANCHISE/CONTRIB/ETC	(31,113)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,825

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ALLIANCE FOR LIVING $15,527**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **0**
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. $ **14,564** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.