FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 01/01/2015 to 12/31/2015 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: 01/01/2015 Ending: 12/31/2015

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	60,513	1,723	2,061	64,297	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,513	1,723	2,061	64,297	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.88%

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 / /

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	360,466	21,626	11,583	393,675		393,675	6,195	399,870			1
2	Food Purchase		296,825		296,825	(15,878)	280,947	(2,175)	278,772			2
3	Housekeeping	127,774	39,470		167,244		167,244		167,244			3
4	Laundry	99,011	13,579	1,744	114,334		114,334		114,334			4
5	Heat and Other Utilities			145,421	145,421		145,421	878	146,299			5
6	Maintenance	31,764	21,565	32,867	86,196		86,196	1,934	88,130			6
7	Other (specify):*			22,478	22,478		22,478	205	22,683			7
8	**TOTAL General Services**	619,015	393,065	214,093	1,226,173	(15,878)	1,210,295	7,037	1,217,332			8
	B. Health Care and Programs											
9	Medical Director			30,750	30,750		30,750		30,750			9
10	Nursing and Medical Records	2,044,947	129,988	25,072	2,200,007		2,200,007	62,463	2,262,470			10
10a	Therapy											10a
11	Activities	98,487	1,235	4,185	103,907		103,907		103,907			11
12	Social Services	298,746		1,271	300,017		300,017		300,017			12
13	CNA Training											13
14	Program Transportation			1,413	1,413		1,413		1,413			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,442,180	131,223	62,691	2,636,094		2,636,094	62,463	2,698,557			16
	C. General Administration											
17	Administrative	114,707		380,000	494,707		494,707	(259,981)	234,726			17
18	Directors Fees											18
19	Professional Services			57,509	57,509		57,509	51,295	108,804			19
20	Dues, Fees, Subscriptions & Promotions			55,492	55,492		55,492	(27,959)	27,533			20
21	Clerical & General Office Expenses	200,453	26,752	20,232	247,437		247,437	81,128	328,565			21
22	Employee Benefits & Payroll Taxes			567,113	567,113	15,878	582,991		582,991			22
23	Inservice Training & Education			3,263	3,263		3,263	965	4,228			23
24	Travel and Seminar							6,168	6,168			24
25	Other Admin. Staff Transportation			2,461	2,461		2,461	778	3,239			25
26	Insurance-Prop.Liab.Malpractice			63,448	63,448		63,448	32,258	95,706			26
27	Other (specify):*			116,021	116,021		116,021	(90,088)	25,933			27
28	**TOTAL General Administration**	315,160	26,752	1,265,539	1,607,451	15,878	1,623,329	(205,436)	1,417,893			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,376,355	551,040	1,542,323	5,469,718		5,469,718	(135,936)	5,333,782			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: 01/01/2015** **Ending: 12/31/2015**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,517	
	REPAIRS & MAINTENANCE		1,066	
				11,583
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,744	
				1,744
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		40,444	
	ELECTRICITY		56,471	
	WATER		47,682	
	CABLE TV - LOBBY		824	
				145,421
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,930	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,454	
	ELEVATOR MAINTENANCE & REPAIR		3,945	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,475	
	FIRE SERVICE		11,063	
				32,867
7	**OTHER**			
	SCAVENGER		21,499	
	SECURITY SERVICE		979	

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		1,149	
	PURCHASED SERVICES		165	
	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	16,380	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	178	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		7,200	
				25,072
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 CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	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	4,185	
				4,185
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	1,271	
	SOCIAL WORKER	XVIII B 45-2	0	

				22,478
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	30,750	30,750

				1,271
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKE PARK CENTER **#0027052** **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,413	
				1,413
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	380,000	380,000
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,677	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	44,832	
				57,509
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,794	
	EMPLOYEE WANT ADS	XIX F	875	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	14,383	
	LICENSES & PERMITS	XIX F	3,158	
	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	31,457	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,000	
	PATIENT BACKGROUND CHECKS	XIX F	1,825	
				55,492
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		252	
	EQUIPMENT REPAIR & MAINTENANCE		230	
	OUTSIDE CLERICAL SERVICES		4,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,750	

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	249,804	
	UNEMPLOYMENT COMPENSATION	XIX D	13,273	
	WORKERS COMPENSATION INSURANC	XIX D	82,288	
	HOSPITALIZATION INSURANCE	XIX D	137,949	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,528	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	80,271	
	CHICAGO HEAD TAX	XIX D	0	
				567,113
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,263	
				3,263
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,461	
				2,461
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		63,448	
				63,448
27	**OTHER**			
	BAD DEBTS	VI 24	116,021	
				116,021

GRAND TOTAL COLUMN 3 OTHER **1,542,323**

MESSENGER SERVICE	0	
		20,232

LAKE PARK CENTER
SCHEDULES
12/31/2015

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

TOTAL FOOD PURCHASE	296,825
LESS SALES TAX	(2,175)
NET FOOD	294,650
TOTAL PATIENT CENSUS	64,297
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	192,891
ADD # EMPLOYEE MEALS/DAY	30
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	192,891
ADD EMPLOYEE MEALS	10,950
TOTAL MEALS/YEAR	203,841
NET FOOD	294,650
DIVIDE TOTAL MEALS/YEAR	203,841
COST PER MEAL	1.45
TIMES EMPLOYEE MEALS	10,950
EMPLOYEE MEAL RECLASSIFICATION	**15,878**

LAKE PARK CENTER
LEGAL INVOICES SCHEDULE
12/31/2015

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICES	ALLOWABLE AMOUNT
1/31/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	2,819
2/28/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,364
3/31/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	654
4/30/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	675
5/31/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	721
6/30/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	805
7/31/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	3,021
8/31/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	765
9/30/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	834
10/31/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	665
11/30/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	444
12/30/2015	STONE,MCGUIRE & SIEGEL	COMPLIANCE LEGAL	1,119
5/26/2015	SEYFARTH SHAW	LOAN MODIFICATION	3,059
TOTAL			**16,945**

Facility Name & ID Number LAKE PARK CENTER #0027052 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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			28,098	28,098		28,098	316,444	344,542			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,761	171,761		171,761	55,482	227,243			32
33	Real Estate Taxes							154,869	154,869			33
34	Rent-Facility & Grounds			800,892	800,892		800,892	(800,892)				34
35	Rent-Equipment & Vehicles			18,328	18,328		18,328	1,159	19,487			35
36	Other (specify):* RENT OFFICE			17,400	17,400		17,400	34,455	51,855			36
37	**TOTAL Ownership**			1,036,479	1,036,479		1,036,479	(238,483)	797,996			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)**	3,376,355	551,040	2,578,802	6,506,197		6,506,197	(374,419)	6,131,778			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: 01/01/2015 Ending: 12/31/2015

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	1,405	30		9
10	Interest and Other Investment Income	(22,623)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,175)	2		13
14	Non-Care Related Interest	(162,086)	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	(31,457)	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	(116,021)	27		24
25	Fund Raising, Advertising and Promotional	(1,794)	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)**	$ (334,751)		$	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)	(39,668)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (39,668)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (374,419)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

LAKE PARK CENTER

ID# 0027052

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	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:** 01/01/2015 **Ending:** 12/31/2015

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	6,195	0	0	0	0	0	0	0	6,195	1
2	Food Purchase	(2,175)	0	0	0	0	0	0	0	0	0	0	(2,175)	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	646	0	232	0	0	0	0	0	0	0	878	5
6	Maintenance	0	1,479	0	455	0	0	0	0	0	0	0	1,934	6
7	Other (specify):*	0	0	0	169	36	0	0	0	0	0	0	205	7
8	**TOTAL General Services**	(2,175)	2,125	0	7,051	36	0	0	0	0	0	0	7,037	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	62,463	0	0	0	0	0	0	0	62,463	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	62,463	0	0	0	0	0	0	0	62,463	16
	C. General Administration													
17	Administrative	0	0	(272,318)	11,068	1,269	0	0	0	0	0	0	(259,981)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	111	10,152	40,707	325	0	0	0	0	0	0	51,295	19
20	Fees, Subscriptions & Promotions	(33,251)	35	0	4,982	275	0	0	0	0	0	0	(27,959)	20
21	Clerical & General Office Expenses	0	116	40	78,924	2,048	0	0	0	0	0	0	81,128	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	965	0	0	0	0	0	0	0	965	23
24	Travel and Seminar	0	0	0	6,168	0	0	0	0	0	0	0	6,168	24
25	Other Admin. Staff Transportation	0	0	0	778	0	0	0	0	0	0	0	778	25
26	Insurance-Prop.Liab.Malpractice	0	168	31,471	619	0	0	0	0	0	0	0	32,258	26
27	Other (specify):*	(116,021)	0	4,087	20,685	1,161	0	0	0	0	0	0	(90,088)	27
28	**TOTAL General Administration**	(149,272)	430	(226,568)	164,896	5,078	0	0	0	0	0	0	(205,436)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(151,447)	2,555	(226,568)	234,410	5,114	0	0	0	0	0	0	(135,936)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	1,405	1,927	312,328	784	0	0	0	0	0	0	0	316,444	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(184,709)	871	239,135	185	0	0	0	0	0	0	0	55,482	32
33	Real Estate Taxes	0	3,399	150,750	720	0	0	0	0	0	0	0	154,869	33
34	Rent-Facility & Grounds	0	0	(800,892)	0	0	0	0	0	0	0	0	(800,892)	34
35	Rent-Equipment & Vehicles	0	179	0	767	213	0	0	0	0	0	0	1,159	35
36	Other (specify):*	0	(17,400)	49,436	2,419	0	0	0	0	0	0	0	34,455	36
37	**TOTAL Ownership**	(183,304)	(11,024)	(49,243)	4,875	213	0	0	0	0	0	0	(238,483)	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)**	(334,751)	(8,469)	(275,811)	239,285	5,327	0	0	0	0	0	0	(374,419)	45

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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						

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				646	646	2
3	V	6	MAINTENANCE				1,479	1,479	3
4	V	19	ACCOUNTING FEES				111	111	4
5	V	20	LICENSES & PERMITS				35	35	5
6	V	21	OFFICE EXPENSE				116	116	6
7	V	26	INSURANCE				168	168	7
8	V	30	DEPRECIATION (SL)				1,927	1,927	8
9	V	32	INTEREST				871	871	9
10	V	33	RE TAX				3,399	3,399	10
11	V	35	STORAGE FEES				179	179	11
12	V								12
13	V								13
14	Total			$ 17,400			$ 8,931	$ * (8,469)	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: 01/01/2015 Ending: 12/31/2015

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	$ 360,000	DA WESTMONT		$	$ (360,000)	15
16	V	17	OFFICER SALARIES-A. WEINFELD				24,294	24,294	16
17	V	17	OFICER SALARIES-D. WEISS				24,294	24,294	17
18	V	17	ADMIN CONSULTANT-A.R.M.				59,094	59,094	18
19	V	19	ACCOUNTING FEES				1,452	1,452	19
20	V	21	OFFICE EXPENSE				40	40	20
21	V	27	PAYROLL TAXES				4,087	4,087	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	800,892	WAUKEGAN TERRACE PROPERTIES LLC			(800,892)	27
28	V	33	REAL ESTATE TAX				150,750	150,750	28
29	V	30	DEPRECIATION (SL)				312,328	312,328	29
30	V	32	INTEREST				233,699	233,699	30
31	V	32	AMORT LOAN COSTS				5,436	5,436	31
32	V	26	INSURANCE				31,471	31,471	32
33	V	36	MIP INSURANCE				49,436	49,436	33
34	V	19	PROFESSIONAL FEES				8,700	8,700	34
35	V								35
36	V								36
37	V								37
38	V	17	MANAGEMENT FEES	20,000	BRIA HEALTH SERVICES			(20,000)	38
39	Total			$ 1,180,892			$ 905,081	$ * (275,811)	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: 01/01/2015 Ending: 12/31/2015

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	CFO SALARY-A.WEINFELD	$	BRIA HEALTH SERVICES		$ 11,068	$ 11,068	15
16	V	10	SALARIES-MDS/NURSING				61,348	61,348	16
17	V	1	SALARIES-DIETARY				6,195	6,195	17
18	V	21	SALARIES-PURCHASING D.SEGAL				12,390	12,390	18
19	V	21	SALARIES-CLERICAL				51,264	51,264	19
20	V	19	ADM CONSULT-D.SEGAL				10,408	10,408	20
21	V	19	ADM CONSULT-F.BERKOVITS				24,780	24,780	21
22	V	5	UTILITIES				232	232	22
23	V	6	MAINTENANCE				455	455	23
24	V	7	SCAVENGER				169	169	24
25	V	10	NURSING CONSULTANT				1,115	1,115	25
26	V	19	PROFESSIONAL FEES				5,519	5,519	26
27	V	20	WANT ADS/BACKGR CKS				4,982	4,982	27
28	V	21	OFFICE EXPENSE				15,270	15,270	28
29	V	23	SEMINARS				965	965	29
30	V	24	TRAVEL				6,168	6,168	30
31	V	25	STAFF TRANSPORTATION				778	778	31
32	V	26	INSURANCE				619	619	32
33	V	27	EMPLOYEE BENEFITS				20,685	20,685	33
34	V	30	DEPRECIATION				784	784	34
35	V	32	INTEREST				185	185	35
36	V	33	RE TAX				720	720	36
37	V	36	OFFICE RENT-HINSDALE MGMT				2,419	2,419	37
38	V	35	STORAGE FEES/AUTO LEASE				767	767	38
39	Total			$			$ 239,285	$ * 239,285	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: 01/01/2015 Ending: 12/31/2015

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	$ 4,000	EKS MANAGEMENT CO		$	$ (4,000)	15
16	V	7	SCAVENGER				36	36	16
17	V	17	CFO SALARY-A. WEINFELD				1,269	1,269	17
18	V	19	PROFESSIONAL FEES				325	325	18
19	V	20	WANT ADS/BACKGR CKS				275	275	19
20	V	21	OFFICE EXPENCE				1,829	1,829	20
21	V	21	CLERICAL SALARIES				2,692	2,692	21
22	V	21	O/S CLERICAL SERVICES BRIA				536	536	22
23	V	21	O/S CLERICAL SERVICES A.R.M.				991	991	23
24	V	27	EMPLOYEE BENEFITS				1,161	1,161	24
25	V	35	EQUIPMENT RENT				213	213	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			$ 4,000			$ 9,327	$ * 5,327	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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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)		ADMIN CONSUL'	3.81	SEE	40	57.14	CONSULT FEE	59,094	17-7	2
3	AVRUM WEINFELD	CFO	CFO	45.24	ATTACHED	15	13.76	SALARIES	24,294	17-7	3
4	DANIEL WEISS		ADMINISTR.	45.24	SCHEDULE	10	11.11	SALARIES	24,294	17-7	4
5											5
6	ALLOCATION FROM BRIA HEALTH SERVICES:										6
7	AVRUM WEINFELD	CFO	CFO					SALARIES	11,068	17-7	7
8											8
9											9
10	ALLOCATION FROM EKS MANAGEMENT:										10
11	AVRUM WEINFELD	CFO	CFO					SALARIES	1,269	17-7	11
12	FLORA WEISS (A.R.M. ENTERPRISES)		O/S CLERICAL					O/S CLERICAI	991	21-7	12
13								TOTAL	$ 121,010		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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: BRIA HEALTH SERVICES LLC
Street Address: 6865 N. LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD
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	CFO SALARY-A.WEINFELD	CENSUS DAYS	518,943	9	$ 89,333	$ 89,333	64,297	$ 11,068	1
2	10	SALARIES-MDS/NURSING	CENSUS DAYS	518,943	9	495,144	495,144	64,297	61,348	2
3	1	SALARIES-DIETARY	CENSUS DAYS	518,943	9	50,000	50,000	64,297	6,195	3
4	21	SALARIES-PURCHASING D.SEGA	CENSUS DAYS	518,943	9	100,000	100,000	64,297	12,390	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	518,943	9	413,753	413,753	64,297	51,264	5
6	19	ADM CONSULT-D.SEGAL	CENSUS DAYS	518,943	9	84,000		64,297	10,408	6
7	19	ADM CONSULT-F.BERKOVITS	CENSUS DAYS	518,943	9	200,000		64,297	24,780	7
8	5	UTILITIES	CENSUS DAYS	518,943	9	1,870		64,297	232	8
9	6	MAINTENANCE	CENSUS DAYS	518,943	9	3,674		64,297	455	9
10	7	SCAVENGER	CENSUS DAYS	518,943	9	1,364		64,297	169	10
11	10	NURSING CONSULTANT	CENSUS DAYS	518,943	9	9,000		64,297	1,115	11
12	19	PROFESSIONAL FEES	CENSUS DAYS	518,943	9	44,548		64,297	5,519	12
13	20	WANT ADS/BACKGR CKS	CENSUS DAYS	518,943	9	40,209		64,297	4,982	13
14	21	OFFICE EXPENSE	CENSUS DAYS	518,943	9	123,241		64,297	15,270	14
15	23	SEMINARS	CENSUS DAYS	518,943	9	7,787		64,297	965	15
16	24	TRAVEL	CENSUS DAYS	518,943	9	49,783		64,297	6,168	16
17	25	STAFF TRANSPORTATION	CENSUS DAYS	518,943	9	6,276		64,297	778	17
18	26	INSURANCE	CENSUS DAYS	518,943	9	4,999		64,297	619	18
19	27	EMPLOYEE BENEFITS	CENSUS DAYS	518,943	9	166,949		64,297	20,685	19
20	30	DEPRECIATION	CENSUS DAYS	518,943	9	6,324		64,297	784	20
21	32	INTEREST	CENSUS DAYS	518,943	9	1,490		64,297	185	21
22	33	RE TAX	CENSUS DAYS	518,943	9	5,814		64,297	720	22
23	36	OFFICE RENT-HINSDALE MGMT	CENSUS DAYS	518,943	9	19,520		64,297	2,419	23
24	35	STORAGE FEES/AUTO LEASE	CENSUS DAYS	518,943	9	6,189		64,297	767	24
25	TOTALS					$ 1,931,267	$ 1,148,230		$ 239,285	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	$ 4,880	$	17,400	$ 646	1
2	6	MAINTENANCE	INCOME	131,400	6	11,170		17,400	1,479	2
3	19	ACCOUNTING FEES	INCOME	131,400	6	839		17,400	111	3
4	20	LICENSES & PERMITS	INCOME	131,400	6	268		17,400	35	4
5	21	OFFICE EXPENSE	INCOME	131,400	6	879		17,400	116	5
6	26	INSURANCE	INCOME	131,400	6	1,270		17,400	168	6
7	30	DEPRECIATION (SL)	INCOME	131,400	6	14,553		17,400	1,927	7
8	32	INTEREST	INCOME	131,400	6	6,577		17,400	871	8
9	33	RE TAX	INCOME	131,400	6	25,670		17,400	3,399	9
10	35	STORAGE FEES	INCOME	131,400	6	1,353		17,400	179	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					$ 67,459	$		$ 8,931	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	158,796	3	$ 60,000	$ 60,000	64,297	$ 24,294	1
2	17	OFICER SALARIES-D. WEISS	CENSUS DAYS	158,796	3	60,000	60,000	64,297	24,294	2
3	17	ADMIN CONSULTANT-A.R.M.	CENSUS DAYS	158,796	3	145,946		64,297	59,094	3
4	19	ACCOUNTING FEES	CENSUS DAYS	158,796	3	3,585		64,297	1,452	4
5	21	OFFICE EXPENSE	CENSUS DAYS	158,796	3	100		64,297	40	5
6	27	PAYROLL TAXES	CENSUS DAYS	158,796	3	10,093		64,297	4,087	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					$ 279,724	$ 120,000		$ 113,261	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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) 674-6795
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	7	SCAVENGER	CENSUS DAYS	291,898	4	$ 162	$	64,297	$ 36	1
2	17	CFO SALARY-A. WEINFELD	CENSUS DAYS	291,898	4	5,760	5,760	64,297	1,269	2
3	19	PROFESSIONAL FEES	CENSUS DAYS	291,898	4	1,474		64,297	325	3
4	20	WANT ADS/BACKGR CKS	CENSUS DAYS	291,898	4	1,250		64,297	275	4
5	21	OFFICE EXPENCE	CENSUS DAYS	291,898	4	8,304		64,297	1,829	5
6	21	CLERICAL SALARIES	CENSUS DAYS	291,898	4	12,219	12,219	64,297	2,692	6
7	21	O/S CLERICAL SERVICES BRIA	CENSUS DAYS	291,898	4	2,432		64,297	536	7
8	21	O/S CLERICAL SERVICES A.R.M.	CENSUS DAYS	291,898	4	4,500		64,297	991	8
9	27	EMPLOYEE BENEFITS	CENSUS DAYS	291,898	4	5,273		64,297	1,161	9
10	35	EQUIPMENT RENT	CENSUS DAYS	291,898	4	967		64,297	213	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					$ 42,341	$ 17,979		$ 9,327	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	CAPITAL ONE FINANCE	X		MORTGAGE	$64,511.91	11/29/12	9,657,100	8,863,409	05/01/39	2.6000	233,699	2
3	LOAN COSTS	X		LOAN COSTS	W/O OVER LOAN		308,376	125,795			5,436	3
4												4
5												5
	Working Capital											
6	THE PRIVATE BANK			WORKING CAPITAL	DEMAND	01/08	1,215,000	517,670		PRIME+	9,675	6
7												7
8	RELATED PARTY ALLOCATION										1,056	8
9	TOTAL Facility Related				$64,511.91		$ 11,180,476	$ 9,506,874			$ 249,866	9
	B. Non-Facility Related*											
10	THE PRIVATE BANK		X	LOAN	$20,833.00	01/15/08	5,155,000	1,959,718		PRIME+	79,966	10
11	M. ESFORMES		X	LOAN	$5,750.00	07/01/10	1,000,000	850,546	01/01/34	4.5000	39,010	11
12												12
13	M. ESFORMES		X	LOAN	$6,000.00	03/01/13	1,500,000	1,420,342	11/01/45	3.0019	43,110	13
14	TOTAL Non-Facility Related				$32,583.00		$ 7,655,000	$ 4,230,606			$ 162,086	14
15	TOTALS (line 9+line14)						$ 18,835,476	$ 13,737,480			$ 411,952	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 49,436 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: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 140,750	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.)		$ 145,026	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,276	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 146,474	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.		$ 150,750	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	157,306	8
	2011	142,166	9
	2012	173,364	10
	2013	139,359	11
	2014	145,026	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 2014 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.**

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-400-032	NURSING HOME	$ 145,025.97	$ 145,025.97
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 145,025.97	$ 145,025.97

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	$	$ 3,319,617	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION					2,085		2,085			8
	Improvement Type**										
9	PAINTING			1986	15,680		15			15,680	9
10	ASHALT PAVING			1987	8,180	260	31.5			8,180	10
11	AVAC UNITS			1988	45,000	1,429	31.5			45,000	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		45,401	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		15,248	13
14	PARKING LOTS			1993	19,440		15			19,440	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	46		1,064	15
16	NURSE STATION			1993	7,800	200	31.5	200		4,622	16
17	ELEVATOR			1994	22,300	572	39	572		11,702	17
18	CUBICLE CURTAINS			1994	843	22	39	22		457	18
19	PARKING LOTS LIGHTS			1995	8,677		15			8,677	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		4,865	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		3,545	21
22	TILE			1996	20,387	522	39	522		9,550	22
23	WEATHER-ROOFTOP			1997	6,408	164	39	164		2,795	23
24	METAL DOORS & AIR CONDITION			1998	11,993	308	39	308		5,197	24
25	TWO SHOWERS			1998	2,720	70	39	70		1,175	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		4,131	26
27	CABINNERY-ADM., BOOKKEPING, DON			1998	33,000	846	39	846		13,783	27
28	WATER HEATER			1998	4,639	119	39	119		1,919	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		1,819	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		10,240	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE			1999	18,547	476	39	476		7,160	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK			1999	8,640	222	39	222		3,358	32
33	FIRE DAMPERS			2000	8,070	293	20	293		4,261	33
34	FENCE			2000	6,810	341	15	409	68	6,391	34
35	CUBICLE CURTAINS			2001	14,018		20	701	701	9,814	35
36	ROOF MAINTENANCE & FLASHING REPAIR			2001	6,950	253	27.5	253		3,542	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: 01/01/2015 Ending: 12/31/2015

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	$	$ 1,428	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895		20	2,245	2,245	31,430	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		14,672	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		6,566	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		15,496	41
42	INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		7,830	42
43	INSTALL STEEL ROLLING DOOR	2006	2,878	105	27.5	105		932	43
44	REPLACE HOT WATER HEATER	2006	8,476	308	27.5	308		2,657	44
45	INSTALL SWING GATES WITH POSTS	2006	1,825	122	15	122		1,098	45
46	SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	992	15	992		8,928	46
47	INSTALL DOORS	2006	171,211	6,226	27.5	6,226		50,067	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		16,538	51
52	INSTALL NEW DURO-LAST ROOF SYSTEM	2007	121,800	4,429	27.5	4,429		33,268	52
53	INSTALLATION OF AIR CLEANING EQUIPMENT	2007	8,736	318	27.5	318		2,478	53
54	AGGREGATE PANELS,FASCIA,SOFFIT-REPAIRS	2007	24,910	906	27.5	906		6,908	54
55	INSTALLATION OF AN ANSUL KITCHEN SYSTEM	2007	8,012	291	27.5	291		2,146	55
56	INSTALL TWO NEW 10 TON ROOFTOP UNITS	2007	23,380	850	27.5	850		5,985	56
57	REPLACE TRANE HEAT EXCHANGER FOR ROOFTOP UNIT	2008	3,925	143	27.5	143		876	57
58	FURNISH AND INSTALLED FOUR DAMPERS	2009	5,340	194	27.5	194		1,091	58
59	MOUNTING 18 CLOSERS, INSTALL NEW DOOR STOP	2009	4,700	171	27.5	171		984	59
60	INSTALL DOORS & HARDWARE IN WINGS 500,600,700,800	2010	9,015	328	27.5	328		1,413	60
61	ELEVATOR-INSTALL 4 NEW GUIDE SHOE ASSEMBLIES	2010	3,900	142	27.5	142		598	61
62	REPLACE DEFECTIVE CIRCUIT BREAKERS	2010	6,800	247	27.5	247		1,039	62
63	INSTALL FIRE/SMOKE DAMPERS	2011	2,790	101	27.5	101		383	63
64	INSTALL NEW HYDRAUTIC ELEVATOR SOFT START	2011	2,200	80	27.5	80		290	64
65	SEALCOAT APPR 44,716 SQUARE FEET; ASPHALT 8 AREAS	2012	6,300	229	27.5	229		525	65
66	REPLACEMENT OF ROOF TOP UNITS & HEAT EXCHYANG	2012	25,630	1,601	7	3,662	2,061	7,441	66
67	REPLACE HEAT EXCHANGER 2ND FLOOR ROTUNDA	2013	3,295	120	27.5	120		355	67
68	CLOSERS FOR FIRE DOORS, FRONT DOOR, BATHROOM								68
69	AND CLOSET SPRING HINGES	2013	6,580	239	27.5	239		647	69
70	TOTAL (lines 4 thru 69)		$ 9,228,553	$ 332,498		$ 335,884	$ 5,075	$ 3,812,702	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: 01/01/2015 Ending: 12/31/2015

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		$ 9,228,553	$ 332,498		$ 335,884	$ 3,386	$ 3,812,702	1
2	REPLACE TWO OLD RHEEM MODEL WATER HEATER	2014	26,875	977	27.5	977		1,669	2
3	INSTALLED NEW DURO-LAST ROOF SYSTEM	2014	27,352	995	27.5	995		1,700	3
4	REPLACEMENT FIRE DOORS	2014	7,865	286	27.5	286		465	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	700	27.5	700		846	7
8	PASSENGER ELEVATOR: INSTALL NEW GFI OUTLET;								8
9	NEW LADDER, DOOR INFRA-RED DETECTOR	2015	9,300	239	27.5	239		239	9
10	1ST AND 2ND FLOOR CORRIDORS, DINING ROOM:								10
11	INSTALL NEW COVE BASE, CHAIR RAILINGS, PAINTING	2015	39,545	300	27.5	300		300	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)		$ 9,358,740	$ 335,995		$ 339,381	$ 3,386	$ 3,817,921	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: 01/01/2015 Ending: 12/31/2015

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	$ 63,213	$ 1,548	$ 4,121	$ 2,573	3-10	$ 51,113	71
72	Current Year Purchases	8,280	4,968	414	(4,554)	10	414	72
73	Fully Depreciated Assets	631,719					631,719	73
74	RELATED PARTY SL DEPRECIATION		626	626				74
75	TOTALS	$ 703,212	$ 7,142	$ 5,161	$ (1,981)		$ 683,246	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)	$ 11,111,952	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 343,137	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 344,542	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,405	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,501,167	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: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 10,048 Description: COPY MACHINE-$6,662 AND STORAGE-$3,386
    (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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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:** 01/01/2015 **Ending:** 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2015 **(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	$ 114,682	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,000)	1,138,754		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,437		6
7	Other Prepaid Expenses	6,887		7
8	Accounts Receivable (owners or related parties)	149,174		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,518,934	$	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	703,212		16
17	Accumulated Depreciation (book methods)	(1,136,213)		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)**	$ 321,095	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,840,029	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,196	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	517,670		29
30	Accrued Salaries Payable	46,090		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,343		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)**	$ 687,299	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,556,024		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)**	$ 3,556,024	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,243,323	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,403,294)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,840,029	$	48

***(See instructions.)**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,364,047)	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,364,042)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(46,028)	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	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES	6,776	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (39,252)	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)**	$ (2,403,294)	24 *

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 6,440,073	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,440,073	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***	22,623	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,623	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)**	$ 6,462,696	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,226,173	31
32	Health Care	2,636,094	32
33	General Administration	1,607,451	33
	B. Capital Expense		
34	Ownership	1,036,479	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)***	$ 6,506,197	40
41	**Income before Income Taxes (line 30 minus line 40)****	(43,501)	41
42	**Income Taxes**	(2,527)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (46,028)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,989,658	44
45	Private Pay - Net Inpatient Revenue	208,920	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify) VETERAN	241,495	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,440,073	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: 01/01/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 74,918	$ 36.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,653	20,517	604,824	29.48	3
4	Licensed Practical Nurses	12,623	13,135	341,891	26.03	4
5	CNAs & Orderlies	72,777	77,531	1,023,314	13.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,487	8,994	98,487	10.95	10
11	Social Service Workers	21,632	21,632	298,746	13.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,016	26,026	360,466	13.85	15
16	Dishwashers					16
17	Maintenance Workers	2,006	2,079	31,764	15.28	17
18	Housekeepers	10,664	11,474	127,774	11.14	18
19	Laundry	8,753	9,330	99,011	10.61	19
20	Administrator	2,080	2,080	114,707	55.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,466	15,199	200,453	13.19	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)	198,237	210,077	$ 3,376,355 *	$ 16.07	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	$ 10,517	1-3	35
36	Medical Director	O	30,750	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	16,380	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	4,185	11-3	44
45	Social Service Consultant	E	1,271	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 63,103		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: 01/01/2015 Ending: 12/31/2015

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
BRIA HEALTH SERVICES	MANAGEMENT FEES	20,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 380,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 4,444
WESTMONT NURSING	DATA PROCESSING	3,000
LTC SOLUTIONS	DATA PROCESSING	1,806
MAXXSOURCE	DATA PROCESSING	911
HDSI	DATA PROCESSING	2,516
KBKB	ACCOUNTING	22,000
PERSONNEL PLANNERS	U.C. CONSULTANT	802
STONE RISIUS ROSS	APPRAISAL FEE	4,038
WALTON MGMT SERVVICE	WOTC CREDITS	1,047
LEGAL FEES	SEE SCHEDULE	16,945
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 57,509

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,288
Unemployment Compensation Insurance	13,273
FICA Taxes	249,804
Employee Health Insurance	137,949
Employee Meals	15,878
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,528
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	80,271
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 582,991

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	875
Health Care Worker Background Check	2,000
(Indicate # of checks performed 74)	
Patient Background Checks 20	1,825
TRUST/FRANCHISE/CONTRIB/ETC	31,457
MARKETING/ADV/PROMO	1,794
LICENSES/DUES/SUBSCRIPTIONS	15,551
MGMT CO ALLOC	5,292
TRUST/FRANCHISE/CONTRIB/ETC	(31,457)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,794)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,533

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MGMT CO ALLOC	6,168
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,168

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:** 01/01/2015 **Ending:** 12/31/2015

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 $ 12,857**

(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. $ **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. $ **15,878** 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 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.