FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 2/1/81

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: KATHLEEN MCNAMARA **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 01/01/2018 to 12/31/2018 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) KATHLEEN MCNAMARA, VICE-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: 01/01/2018 Ending: 12/31/2018

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	60,000	615	1,118	61,733	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,000	615	1,118	61,733	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.54%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 2/1/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/81 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 [ ] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	277,995	13,398	26,612	318,005		318,005		318,005			1
2	Food Purchase		288,309		288,309	(6,658)	281,651	(604)	281,047			2
3	Housekeeping	205,612	36,511		242,123		242,123		242,123			3
4	Laundry	40,876	94,507		135,383		135,383		135,383			4
5	Heat and Other Utilities			114,858	114,858		114,858		114,858			5
6	Maintenance	39,200	39,358	24,219	102,777		102,777	1,096	103,873			6
7	Other (specify):*			23,946	23,946		23,946	173	24,119			7
8	**TOTAL General Services**	563,683	472,083	189,635	1,225,401	(6,658)	1,218,743	665	1,219,408			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	1,861,737	121,359	38,949	2,022,045		2,022,045	26,825	2,048,870			10
10a	Therapy											10a
11	Activities	93,445	1,242	5,804	100,491		100,491		100,491			11
12	Social Services	273,201	1,980	2,948	278,129		278,129		278,129			12
13	CNA Training											13
14	Program Transportation			384	384		384		384			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,228,383	124,581	90,085	2,443,049		2,443,049	26,825	2,469,874			16
	C. General Administration											
17	Administrative	115,710		360,000	475,710		475,710	(434,780)	40,930			17
18	Directors Fees											18
19	Professional Services			181,022	181,022		181,022	19,433	200,455			19
20	Dues, Fees, Subscriptions & Promotions			74,982	74,982		74,982	(34,642)	40,340			20
21	Clerical & General Office Expenses	241,790	26,380	66,096	334,266		334,266	107,424	441,690			21
22	Employee Benefits & Payroll Taxes			501,389	501,389	6,658	508,047		508,047			22
23	Inservice Training & Education			17,964	17,964		17,964	893	18,857			23
24	Travel and Seminar			5,830	5,830		5,830	4,205	10,035			24
25	Other Admin. Staff Transportation							(947)	(947)			25
26	Insurance-Prop.Liab.Malpractice			81,819	81,819		81,819	32,854	114,673			26
27	Other (specify):*			72,000	72,000		72,000	27,939	99,939			27
28	**TOTAL General Administration**	357,500	26,380	1,361,102	1,744,982	6,658	1,751,640	(277,621)	1,474,019			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,149,566	623,044	1,640,822	5,413,432		5,413,432	(250,131)	5,163,301			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	26,612	
	REPAIRS & MAINTENANCE			
				26,612
3	**HOUSEKEEPING**			
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE			
				0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		27,069	
	ELECTRICITY		42,901	
	WATER		42,460	
	CABLE TV - LOBBY		2,428	
				114,858
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,640	
	PAINTING & DECORATING			
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		1,439	
	ELEVATOR MAINTENANCE & REPAIR			
	OUTSIDE LABOR			
	EXTERMINATING SERVICE			
	FIRE SERVICE		15,140	
				24,219
7	**OTHER**			
	SCAVENGER AND EXTERMINATING SERVICES		23,946	
	SECURITY SERVICE			
				23,946
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	42,000	42,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		363	
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2		
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2		
	PHARMACY CONSULTANT	XVIII B 39-2	20,286	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2	11,100	
	RN CONSULTANT	XVIII B 38-2		
	DENTAL		7,200	
				38,949
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2		
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2		
	SPEECH THERAPY CONSULTANT	XVIII B 43-2		
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	5,804	
				5,804
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	2,948	
	SOCIAL WORKER	XVIII B 45-2		
				2,948
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number LAKE PARK CENTER **#0027052** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		384	
				384
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	360,000	360,000
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,353	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	42,669	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		132,000	181,022
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	582	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	11,102	
	CONTRIBUTIONS	VI 20 XIX F	300	
	DUES & SUBSCRIPTIONS	XIX F	12,520	
	LICENSES & PERMITS	XIX F	3,677	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	41,720	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	806	
	PATIENT BACKGROUND CHECKS	XIX F	4,275	
				74,982
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,489	
	EQUIPMENT REPAIR & MAINTENANCE		43,706	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18		
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		19,901	
	MESSENGER SERVICE			
				66,096

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	233,080	
	UNEMPLOYMENT COMPENSATION	XIX D	11,502	
	WORKERS COMPENSATION INSURANC	XIX D	97,082	
	HOSPITALIZATION INSURANCE	XIX D	75,036	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,450	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D	83,239	
				501,389
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		17,964	
				17,964
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	5,830	
				5,830
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF			
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		81,819	
				81,819
27	**OTHER**			
	BAD DEBTS	VI 24	72,000	
				72,000

GRAND TOTAL COLUMN 3 OTHER **1,640,822**

LAKE PARK CENTER
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	288,309
LESS SALES TAX	(604)
NET FOOD	287,705
TOTAL PATIENT CENSUS	61,733
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	185,199
ADD # EMPLOYEE MEALS/DAY	12
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	4,380
PATIENT MEALS	185,199
ADD EMPLOYEE MEALS	4,380
TOTAL MEALS/YEAR	189,579
NET FOOD	287,705
DIVIDE TOTAL MEALS/YEAR	189,579
COST PER MEAL	1.52
TIMES EMPLOYEE MEALS	4,380
EMPLOYEE MEAL RECLASSIFIC	**6,658**

Facility Name & ID Number LAKE PARK CENTER #0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			29,506	29,506		29,506	316,408	345,914			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,500	88,500		88,500	182,960	271,460			32
33	Real Estate Taxes							86,551	86,551			33
34	Rent-Facility & Grounds			783,881	783,881		783,881	(783,881)				34
35	Rent-Equipment & Vehicles			18,961	18,961		18,961	2,847	21,808			35
36	Other (specify):* RENT OFFICE			17,400	17,400		17,400	44,773	62,173			36
37	**TOTAL Ownership**			938,248	938,248		938,248	(150,342)	787,906			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)**	3,149,566	623,044	2,579,070	6,351,680		6,351,680	(400,473)	5,951,207			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: 01/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,652)	30		9
10	Interest and Other Investment Income	(5,738)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(604)	2		13
14	Non-Care Related Interest	(65,978)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(42,020)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(582)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(947)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (117,521)		$	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)	(282,952)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (282,952)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (400,473)		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	TRAVEL-MARKETING	$ (947)	25	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**	(947)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(604)	0	0	0	0	0	0	0	0	0	0	(604)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	1,096	0	0	0	0	0	0	0	1,096	6
7	Other (specify):*	0	0	0	173	0	0	0	0	0	0	0	173	7
8	**TOTAL General Services**	(604)	0	0	1,269	0	0	0	0	0	0	0	665	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	26,825	0	0	0	0	0	0	0	26,825	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	26,825	0	0	0	0	0	0	0	26,825	16
	C. General Administration													
17	Administrative	0	(313,780)	0	(121,000)	0	0	0	0	0	0	0	(434,780)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,321	12,700	5,412	0	0	0	0	0	0	0	19,433	19
20	Fees, Subscriptions & Promotions	(42,602)	0	0	7,960	0	0	0	0	0	0	0	(34,642)	20
21	Clerical & General Office Expenses	0	65	0	107,359	0	0	0	0	0	0	0	107,424	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	893	0	0	0	0	0	0	0	893	23
24	Travel and Seminar	0	0	0	4,205	0	0	0	0	0	0	0	4,205	24
25	Other Admin. Staff Transportation	(947)	0	0	0	0	0	0	0	0	0	0	(947)	25
26	Insurance-Prop.Liab.Malpractice	0	0	29,594	3,260	0	0	0	0	0	0	0	32,854	26
27	Other (specify):*	0	3,621	0	24,318	0	0	0	0	0	0	0	27,939	27
28	**TOTAL General Administration**	(43,549)	(308,773)	42,294	32,407	0	0	0	0	0	0	0	(277,621)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(44,153)	(308,773)	42,294	60,501	0	0	0	0	0	0	0	(250,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(1,652)	0	313,108	4,952	0	0	0	0	0	0	0	316,408	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(71,716)	0	217,090	37,586	0	0	0	0	0	0	0	182,960	32
33	Real Estate Taxes	0	0	86,551	0	0	0	0	0	0	0	0	86,551	33
34	Rent-Facility & Grounds	0	0	(783,881)	0	0	0	0	0	0	0	0	(783,881)	34
35	Rent-Equipment & Vehicles	0	0	0	2,847	0	0	0	0	0	0	0	2,847	35
36	Other (specify):*	0	0	44,773	0	0	0	0	0	0	0	0	44,773	36
37	**TOTAL Ownership**	(73,368)	0	(122,359)	45,385	0	0	0	0	0	0	0	(150,342)	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)**	(117,521)	(308,773)	(80,065)	105,886	0	0	0	0	0	0	0	(400,473)	45

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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)		Sum_6
1	V	17	MANAGEMENT FEES	$ 360,000	DA WESTMONT		$	$ (360,000)	1	(360,000)
2	V	17	OFFICER SALARIES-A. WEINFELD				23,110	23,110	2	23,110
3	V	17	OFICER SALARIES-D. WEISS				23,110	23,110	3	23,110
4	V	19	ACCOUNTING FEES				1,321	1,321	4	1,321
5	V	21	OFFICE EXPENSES				65	65	5	65
6	V	27	PAYROLL TAXES				3,621	3,621	6	3,621
7	V								7	
8	V								8	
9	V								9	
10	V								10	
11	V								11	
12	V								12	
13	V								13	
14	Total			$ 360,000			$ 51,227	$ * (308,773)	14	

Line Line

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 783,881	WAUKEGAN TERRACE PROPERTIES LLC		$	$ (783,881)	15
16	V	33	REAL ESTATE TAX				86,551	86,551	16
17	V	30	DEPRECIATION (SL)				313,108	313,108	17
18	V	32	INTEREST				211,654	211,654	18
19	V	32	AMORT LOAN COSTS				5,436	5,436	19
20	V	26	INSURANCE				29,594	29,594	20
21	V	36	MIP INSURANCE				44,773	44,773	21
22	V	19	PROFESSIONAL FEES				12,700	12,700	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			$ 783,881			$ 703,816	$ * (80,065)	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: 01/01/2018 Ending: 12/31/2018

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	BOOKKEEPING/ADMINISTRATIVE	$ 132,000	BRIA HEALTH SERVICES		$	$ (132,000)	15
16	V	17	CFO SALARY-A.WEINFELD				11,000	11,000	16
17	V	10	SALARIES-MEDICARE/NURSING				25,965	25,965	17
18	V	21	SALARIES-PURCHASING D.SEGAL				7,790	7,790	18
19	V	21	SALARIES-CLERICAL RELATED PARTIES						19
20	V	21	SALARIES-CLERICAL				80,163	80,163	20
21	V	6	MAINTENANCE				1,096	1,096	21
22	V	7	SCAVENGER				173	173	22
23	V	10	NURSING CONSULTANT				860	860	23
24	V	19	PROFESSIONAL FEES				5,412	5,412	24
25	V	20	DUES,FEES,SUBSCRIPTIONS				7,960	7,960	25
26	V	21	OFFICE EXPENSE				19,406	19,406	26
27	V	23	SEMINARS				893	893	27
28	V	24	TRAVEL				4,205	4,205	28
29	V	26	INSURANCE				3,260	3,260	29
30	V	27	EMPLOYEE BENEFITS				24,318	24,318	30
31	V	30	DEPRECIATION				4,952	4,952	31
32	V	32	INTEREST				37,586	37,586	32
33	V	35	AUTO LEASE				1,548	1,548	33
34	V	35	EQUIPMENT RENTAL				1,299	1,299	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 132,000			$ 237,886	$ * 105,886	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: 01/01/2018 Ending: 12/31/2018

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	AVRUM WEINFELD	45.24	BRIA OF CAHOKIA	CAHOKIA	IME REALTY CORP	SKOKIE	HOME OFFICE	1
2								2
3	DANIEL WEISS	45.24	BRIA OF FOREST EDGE	CHICAGO	DA WESTMONT	SKOKIE	MGMT CONSULT	3
4								4
5	FLORA WEISS	3.81	BRIA OF BELLEVILLE	BELLEVILLE	BRIA HEALTH			5
6					SERVICES, LLC	SKOKIE	MANAGEMENT	6
7	D'VORAH WEINFELD	1.43	BRIA OF GENEVA	GENEVA				7
8					WAUKEGAN			8
9	MIRIAM WEINFELD ROBINSON	2.85	BRIA OF WESTMONT	WESTMONT	PROPERTIES, LLC	SKOKIE	REAL ESTATE	9
10								10
11	RIVKA WEISS	1.43	BRIA OF CHICAGO HEIGHTS	SOUTH CHICAGO				11
12				HEIGHTS				12
13								13
14			BRIA OF PALOS HILLS	PALOS HILLS				14
15								15
16			BRIA OF RIVER OAKS	BURNHAM				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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					SEE						2
3	AVRUM WEINFELD		CFO	45.24	ATTACHED	4	10.00	SALARIES	15,000	17-7	3
4	DANIEL WEISS		ADMINISTR.	45.24	SCHEDULE	4	10.00	SALARIES	20,000	17-7	4
5											5
6	ALLOCATION FROM BRIA HEALTH SERVICES:										6
7	AVRUM WEINFELD		CFO	45.24		4	10.00	SALARIES	11,000	17-7	7
8											8
9	ALLOCATION FROM WEISS MANAGEMENT GROUP:										9
10	DANIEL WEISS		ADMINISTR.	45.24		4	10.00	SALARIES	12,000	17-7	10
11											11
12											12
13								TOTAL	$ 58,000		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

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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: 5151 CHURCH STREET
City / State / Zip Code: SKOKIE, IL 60077
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. WEINFELI	CENSUS DAYS	160,275	3	$ 60,000	$ 60,000	61,733	$ 23,110	1
2	17	OFICER SALARIES-D. WEISS	CENSUS DAYS	160,275	3	60,000	60,000	61,733	23,110	2
3	19	ACCOUNTING FEES	CENSUS DAYS	160,275	3	3,430		61,733	1,321	3
4	21	OFFICE EXPENSES	CENSUS DAYS	160,275	3	168		61,733	65	4
5	27	PAYROLL TAXES	CENSUS DAYS	160,275	3	9,400		61,733	3,621	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					$ 132,998	$ 120,000		$ 51,227	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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: 5151 CHURCH STREET
City / State / Zip Code: SKOKIE, IL 60077
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	wghtd avr hours		9	$ 99,000	$ 99,000		$ 11,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	516,944	9	217,425	217,425	61,733	25,965	2
3	21	SALARIES-PURCHASING D.SEGA	wghtd avr hours		9	148,012	148,012		7,790	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours		9	41,826	41,826			4
5	21	SALARIES-CLERICAL	CENSUS DAYS	516,944	9	671,273	671,273	61,733	80,163	5
6	6	MAINTENANCE	CENSUS DAYS	516,944	9	9,177		61,733	1,096	6
7	7	SCAVENGER	CENSUS DAYS	516,944	9	1,451		61,733	173	7
8	10	NURSING CONSULTANT	CENSUS DAYS	516,944	9	7,200		61,733	860	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	516,944	9	45,319		61,733	5,412	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	516,944	9	66,654		61,733	7,960	10
11	21	OFFICE EXPENSE	CENSUS DAYS	516,944	9	162,507		61,733	19,406	11
12	23	SEMINARS	CENSUS DAYS	516,944	9	7,477		61,733	893	12
13	24	TRAVEL	CENSUS DAYS	516,944	9	35,214		61,733	4,205	13
14	26	INSURANCE	CENSUS DAYS	516,944	9	27,300		61,733	3,260	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	516,944	9	203,639		61,733	24,318	15
16	30	DEPRECIATION	CENSUS DAYS	516,944	9	41,469		61,733	4,952	16
17	32	INTEREST	CENSUS DAYS	516,944	9	314,739		61,733	37,586	17
18	35	AUTO LEASE	CENSUS DAYS	516,944	9	12,960		61,733	1,548	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	516,944	9	10,875		61,733	1,299	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,123,517	$ 1,177,536		$ 237,886	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	8,005,404	05/01/39	2.6000	211,654	2
3	LOAN COSTS	X		LOAN COSTS	W/O OVER LOAN		308,376	109,487			5,436	3
4												4
5												5
	Working Capital											
6	THE PRIVATE BANK	X		WORKING CAPITAL	DEMAND	01/08	1,215,000	450,250		PRIME+	22,469	6
7		X		INSURANCE FINANCE							53	7
8	RELATED PARTY ALLOCATION										37,586	8
9	TOTAL Facility Related				$64,511.91		$ 11,180,476	$ 8,565,141			$ 277,198	9
	B. Non-Facility Related*											
10	THE PRIVATE BANK		X	LOAN	$22,500.00	01/15/08	5,155,000	1,138,175		PRIME+	65,978	10
11	M. ESFORMES		X	LOAN	$5,750.00	07/01/10	1,000,000	819,179	01/01/34	4.5000		11
12												12
13	M. ESFORMES		X	LOAN	$6,000.00	03/01/13	1,500,000	1,390,573	11/01/45	3.0019		13
14	TOTAL Non-Facility Related				$34,250.00		$ 7,655,000	$ 3,347,927			$ 65,978	14
15	TOTALS (line 9+line14)						$ 18,835,476	$ 11,913,068			$ 343,176	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 44,773 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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	104,042	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.)	$	94,823	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,219)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	95,771	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.	$	86,552	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	139,359	8
2014	145,026	9
2015	144,696	10
2016	103,011	11
2017	94,823	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE PARK CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027052

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-400-032	NURSING HOME	$ 94,822.69	$ 94,822.69
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 94,822.69	$ 94,822.69

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,715 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [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: 01/01/2018 Ending: 12/31/2018

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	$	$ 4,208,139	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				86,369	2,437		2,437			8
	Improvement Type**										
9	PAINTING			1986	15,680		15			15,680	9
10	ASHALT PAVING			1987	8,180	260	31.5		(260)	8,180	10
11	AVAC UNITS			1988	45,000	1,429	31.5		(1,429)	45,000	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		50,813	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		17,198	13
14	PARKING LOTS			1993	19,440		15			19,440	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	46		1,202	15
16	NURSE STATION			1993	7,800	200	31.5	200		5,222	16
17	ELEVATOR			1994	22,300	572	39	572		13,418	17
18	CUBICLE CURTAINS			1994	843	22	39	22		523	18
19	PARKING LOTS LIGHTS			1995	8,677		15			8,677	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		5,615	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		4,100	21
22	TILE			1996	20,387	522	39	522		11,116	22
23	WEATHER-ROOFTOP			1997	6,408	164	39	164		3,287	23
24	METAL DOORS & AIR CONDITION			1998	11,993	308	39	308		6,121	24
25	TWO SHOWERS			1998	2,720	70	39	70		1,385	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		4,884	26
27	CABINNERY-ADM., BOOKKEPING, DON			1998	33,000	846	39	846		16,321	27
28	WATER HEATER			1998	4,639	119	39	119		2,276	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		2,170	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		12,238	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE			1999	18,547	476	39	476		8,588	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK			1999	8,640	222	39	222		4,024	32
33	FIRE DAMPERS			2000	8,070	293	20	293		5,140	33
34	FENCE			2000	6,810		15			6,810	34
35	CUBICLE CURTAINS			2001	14,018		20	701	701	11,917	35
36				2001	6,950	253	27.5	253		4,301	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: 01/01/2018 Ending: 12/31/2018

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	$	$ 1,734	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895		20	2,245	2,245	38,165	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		17,816	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		7,973	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		19,330	41
42	INSTALL DUTCH DOORS & DOOR MAGNETS	2005	23,803	866	27.5	866		10,428	42
43	INSTALL STEEL ROLLING DOOR	2006	2,878	105	27.5	105		1,247	43
44	REPLACE HOT WATER HEATER	2006	8,476	308	27.5	308		3,581	44
45	INSTALL SWING GATES WITH POSTS	2006	1,825	122	15	122		1,464	45
46	SEAL COATING PARKING LOT & NEW SIDEWALKS	2006	14,875	992	15	992		11,904	46
47	INSTALL DOORS	2006	171,211	6,226	27.5	6,226		68,745	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		23,342	51
52	INSTALL NEW DURO-LAST ROOF SYSTEM	2007	121,800	4,429	27.5	4,429		46,555	52
53	INSTALLATION OF AIR CLEANING EQUIPMENT	2007	8,736	318	27.5	318		3,432	53
54	AGGREGATE PANELS,FASCIA,SOFFIT-REPAIRS	2007	24,910	906	27.5	906		9,626	54
55	INSTALLATION OF AN ANSUL KITCHEN SYSTEM	2007	8,012	291	27.5	291		3,019	55
56	INSTALL TWO NEW 10 TON ROOFTOP UNITS	2007	23,380	850	27.5	850		8,535	56
57	REPLACE TRANE HEAT EXCHANGER FOR ROOFTOP UNIT	2008	3,925	143	27.5	143		1,305	57
58	FURNISH AND INSTALLED FOUR DAMPERS	2009	5,340	194	27.5	194		1,673	58
59	MOUNTING 18 CLOSERS, INSTALL NEW DOOR STOP	2009	4,700	171	27.5	171		1,497	59
60	INSTALL DOORS & HARDWARE IN WINGS 500,600,700,800	2010	9,015	328	27.5	328		2,397	60
61	ELEVATOR-INSTALL 4 NEW GUIDE SHOE ASSEMBLIES	2010	3,900	142	27.5	142		1,024	61
62	REPLACE DEFECTIVE CIRCUIT BREAKERS	2010	6,800	247	27.5	247		1,780	62
63	INSTALL FIRE/SMOKE DAMPERS	2011	2,790	101	27.5	101		686	63
64	INSTALL NEW HYDRAUTIC ELEVATOR SOFT START	2011	2,200	80	27.5	80		530	64
65	SEALCOAT APPR 44,716 SQUARE FEET; ASPHALT 8 AREAS	2012	6,300	229	27.5	229		1,212	65
66	REPLACEMENT OF ROOF TOP UNITS & HEAT EXCHYANG	2012	25,630	1,144	7	1,144		10,872	66
67	REPLACE HEAT EXCHANGER 2ND FLOOR ROTUNDA	2013	3,295	120	27.5	120		715	67
68	CLOSERS FOR FIRE DOORS, FRONT DOOR, BATHROOM								68
69	AND CLOSET SPRING HINGES	2013	6,580	239	27.5	239		1,364	69
70	TOTAL (lines 4 thru 69)		$ 9,314,922	$ 332,052		$ 333,309	$ 1,257	$ 4,805,736	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: 01/01/2018 Ending: 12/31/2018

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		$ 9,314,922	$ 332,052		$ 333,309	$ 1,257	$ 4,805,736	1
2	REPLACE TWO OLD RHEEM MODEL WATER HEATER	2014	26,875	977	27.5	977		4,600	2
3	INSTALLED NEW DURO-LAST ROOF SYSTEM	2014	27,352	995	27.5	995		4,685	3
4	REPLACEMENT FIRE DOORS	2014	7,865	286	27.5	286		1,323	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		2,946	7
8	PASSENGER ELEVATOR: INSTALL NEW GFI OUTLET;								8
9	NEW LADDER, DOOR INFRA-RED DETECTOR	2015	9,300	338	27.5	338		1,253	9
10	1ST AND 2ND FLOOR CORRIDORS, DINING ROOM:								10
11	INSTALL NEW COVE BASE, CHAIR RAILINGS, PAINTING	2015	39,545	1,438	27.5	1,438		4,614	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)		$ 9,445,109	$ 336,786		$ 338,043	$ 1,257	$ 4,825,157	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: 01/01/2018 Ending: 12/31/2018

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	$ 51,728	$ 4,605	$ 5,173	$ 568	3-10	$ 16,973	71
72	Current Year Purchases	3,660	3,660	183	(3,477)	10	183	72
73	Fully Depreciated Assets	678,803					678,803	73
74	RELATED PARTY SL DEPRECIATION		2,515	2,515				74
75	TOTALS	$ 734,191	$ 10,780	$ 7,871	$ (2,909)		$ 695,959	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)	$ 11,229,300	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 347,566	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 345,914	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,652)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,521,116	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: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 9,895 Description: COPY MACHINE-$5,930 AND STORAGE-$3,965
(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	2017 FORD	$ 749.28	$ 9,066	17
18					18
19					19
20					20
21	TOTAL		$ 749.28	$ 9,066	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: 01/01/2018 Ending: 12/31/2018

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.

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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2								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: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 12,886	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 144,000)	1,689,403		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,200		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	64,253		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,824,742	$	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	734,191		16
17	Accumulated Depreciation (book methods)	(1,230,340)		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)**	$ 257,947	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,082,689	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 316,907	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	483,469		29
30	Accrued Salaries Payable	78,983		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,301		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)**	$ 888,660	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,673,345		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)**	$ 2,673,345	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,562,005	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,479,316)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,082,689	$	48

*(See instructions.)

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,577,796)	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,577,793)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	98,477	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		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 98,477	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)**	$ (1,479,316)	24 *

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

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 6,445,393	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,445,393	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***	5,738	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,738	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)**	$ 6,451,131	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,225,401	31
32	Health Care	2,443,049	32
33	General Administration	1,744,982	33
	B. Capital Expense		
34	Ownership	938,248	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)***	$ 6,351,680	40
41	**Income before Income Taxes (line 30 minus line 40)****	99,451	41
42	**Income Taxes**	(974)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 98,477	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,240,720	44
45	Private Pay - Net Inpatient Revenue	70,680	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify) MANAGED CARE	133,993	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,445,393	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: 01/01/2018 Ending: 12/31/2018

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	1,968	2,192	$ 78,949	$ 36.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,825	17,073	531,862	31.15	3
4	Licensed Practical Nurses	12,365	13,069	346,118	26.48	4
5	CNAs & Orderlies	58,642	62,909	904,808	14.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,313	7,968	93,445	11.73	10
11	Social Service Workers	16,264	17,672	273,201	15.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,973	22,288	277,995	12.47	15
16	Dishwashers					16
17	Maintenance Workers	1,968	2,112	39,200	18.56	17
18	Housekeepers	15,477	16,242	205,612	12.66	18
19	Laundry	2,902	3,135	40,876	13.04	19
20	Administrator	1,936	2,080	115,710	55.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,233	19,321	241,790	12.51	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)	173,866	186,061	$ 3,149,566 *	$ 16.93	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	$ 26,612	1-3	35
36	Medical Director	O	42,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	20,286	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	5,804	11-3	44
45	Social Service Consultant	E	2,948	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 97,650		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: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROBERT BRYAN LIVINGS	ADMINISTRATOR	0	$ 115,710
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 115,710

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 6,353
KBKB	ACCOUNTING	18,000
PERSONNEL PLANNERS	U.C. CONSULTANT	1,044
BRIA HEALTH SERVICE	BOOKKEEPING/ADM.SEV	132,000
SEE LEGAL SCHEDULE ATTACHED		23,625
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 181,022

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 97,082
Unemployment Compensation Insurance		11,502
FICA Taxes		233,080
Employee Health Insurance		75,036
Employee Meals		6,658
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,450
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		83,239
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 508,047

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	11,102
Health Care Worker Background Check	806
(Indicate # of checks performed 35)	
Patient Background Checks 117	4,275
TRUST/FRANCHISE/CONTRIB/ETC	42,020
MARKETING/ADV/PROMO	582
LICENSES/DUES/SUBSCRIPTIONS	14,207
MGMT CO ALLOC	7,960
TRUST/FRANCHISE/CONTRIB/ETC	(42,020)
Less: Public Relations Expense	(0)
Non-allowable advertising	(582)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,340

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,830
MGMT CO ALLOC	4,205
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,035

* Attach copy of IMRF notifications

**See instructions.

LAKE PARK CENTER
LEGAL SCHEDULE
12/31/2018

DATE	FIRM NAME	DESCRIPTION OF SERVICES	AMOUNT
1/1/2018	CARDEN AND SAX LLC	LEGAL COMPLIANCE	3,000
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	550
2/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	171
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
3/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
4/2/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
5/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	506
6/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
7/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
8/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
9/4/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
9/4/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
10/1/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	173
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500
12/3/2018	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	167
2/1818	SKIDELSKY AND ASSOCIATES	REAL ESTATE ASSESSMENT	3,105
1/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
2/28/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
3/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
4/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	3,787
5/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
6/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
7/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
9/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
10/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
11/30/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
12/31/2018	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700
TOTAL			**23,625**

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 $ 12,520**

(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. $ **6,658** 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