FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0050740

Facility Name: Park House Nursing & Rehab Ctr

Address: 2320 S. Lawndale Avenue (Number) Chicago (City) 60623 (Zip Code)

County: Cook

Telephone Number: (773) 522-0400 **Fax #** (773) 522-1692

HFS ID Number:

Date of Initial License for Current Owners: 12/23/2009

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Lisa Hanlon
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 N/A

	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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	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		318	2,067	2,385	8
9	SNF/PED					9
10	ICF	31,274			31,274	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,274	318	2,067	33,659	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.00%

D. How many bed-hold days during this year were paid by the Department?
None (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 12/23/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/23/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 2,067

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	198,153	17,382	8,581	224,116		224,116	2,674	226,790			1
2	Food Purchase		173,924		173,924		173,924	227	174,151			2
3	Housekeeping	109,741	27,284		137,025		137,025	347	137,372			3
4	Laundry	42,550	7,189		49,739		49,739	(188)	49,551			4
5	Heat and Other Utilities			84,544	84,544		84,544	783	85,327			5
6	Maintenance	66,094		94,415	160,509		160,509	6,494	167,003			6
7	Other (specify):*							1,095	1,095			7
8	**TOTAL General Services**	416,538	225,779	187,540	829,857		829,857	11,432	841,289			8
	B. Health Care and Programs											
9	Medical Director			37,700	37,700		37,700		37,700			9
10	Nursing and Medical Records	1,274,788	22,192	11,638	1,308,618		1,308,618	15,055	1,323,673			10
10a	Therapy	65,304	241		65,545		65,545	2,407	67,952			10a
11	Activities	75,745	9,046	2,964	87,755		87,755		87,755			11
12	Social Services	262,705	15,619	25,500	303,824		303,824	1,722	305,546			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,119	3,119			15
16	**TOTAL Health Care and Programs**	1,678,542	47,098	77,802	1,803,442		1,803,442	22,303	1,825,745			16
	C. General Administration											
17	Administrative	93,160			93,160		93,160	30,888	124,048			17
18	Directors Fees											18
19	Professional Services			265,333	265,333	(3,000)	262,333	(153,537)	108,796			19
20	Dues, Fees, Subscriptions & Promotions			20,562	20,562		20,562	(6,421)	14,141			20
21	Clerical & General Office Expenses	43,119	20,360	127,271	190,750		190,750	(11,151)	179,599			21
22	Employee Benefits & Payroll Taxes			430,711	430,711		430,711	(13,967)	416,744			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,156	3,156		3,156	914	4,070			24
25	Other Admin. Staff Transportation			12,540	12,540		12,540	(3,811)	8,729			25
26	Insurance-Prop.Liab.Malpractice			76,526	76,526		76,526	582	77,108			26
27	Other (specify):*							20,588	20,588			27
28	**TOTAL General Administration**	136,279	20,360	936,099	1,092,738	(3,000)	1,089,738	(135,915)	953,823			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,231,359	293,237	1,201,441	3,726,037	(3,000)	3,723,037	(102,180)	3,620,857			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Number Park House Nursing & Rehab Ctr #0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							120,565	120,565			30
31	Amortization of Pre-Op. & Org.			338	338		338	(338)				31
32	Interest			17,838	17,838		17,838	242,828	260,666			32
33	Real Estate Taxes			75,821	75,821	3,000	78,821	1,135	79,956			33
34	Rent-Facility & Grounds			450,603	450,603		450,603	(449,341)	1,262			34
35	Rent-Equipment & Vehicles			17,022	17,022		17,022	842	17,864			35
36	Other (specify):*											36
37	**TOTAL Ownership**			561,622	561,622	3,000	564,622	(84,309)	480,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		136,815	139,226	276,041		276,041	(8,249)	267,792			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		136,815	197,261	334,076		334,076	(8,249)	325,827			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,231,359	430,052	1,960,324	4,621,735		4,621,735	(194,737)	4,426,998			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	74,609	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	02		13
14	Non-Care Related Interest				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	(7,228)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,000)	21		24
25	Fund Raising, Advertising and Promotional	(8,358)	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	(14,714)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,707)		$	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)	(155,030)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (155,030)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (194,737)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Park House Nursing & Rehab Ctr

ID# 0050740

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (1,319)	10	1
2	Theft Loss	(594)	21	2
3	Collection Expense	(377)	21	3
4	Non-Allowable Amortization	(338)	31	4
5	Non-Allowable Auto	(4,256)	25	5
6	Non-Allowable Legal	(3,811)	19	6
7	Building Co- Bank Service Fee	(3,452)	21	7
8	Building Co-Administrative Expense	(150)	21	8
9	Non-Allowable Lease Expense	(417)	35	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**	(14,714)		49

Park House Nursing & Rehab Ctr

ID# 0050740

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			87		2,587							2,674	1
2	Food Purchase	(16)		243									227	2
3	Housekeeping			313		34							347	3
4	Laundry								(188)				(188)	4
5	Heat and Other Utilities			710		73							783	5
6	Maintenance			2,042	4,380	72							6,494	6
7	Other (specify):*				732	363							1,095	7
8	**TOTAL General Services**	(16)		3,395	5,112	3,129			(188)				11,432	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,319)				16,645			(270)				15,055	10
10a	Therapy					2,407							2,407	10a
11	Activities													11
12	Social Services					1,722							1,722	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					2,912	207						3,119	15
16	**TOTAL Health Care and Programs**	(1,319)				23,686	207		(270)				22,303	16
	C. General Administration													
17	Administrative			1,447	5,619	23,822							30,888	17
18	Directors Fees													18
19	Professional Services	(3,811)		(130,443)		(19,283)							(153,537)	19
20	Fees, Subscriptions & Promotions	(8,358)		1,834		103							(6,421)	20
21	Clerical & General Office Expenses	(95,801)	3,602	8,571	68,102	4,375							(11,151)	21
22	Employee Benefits & Payroll Taxes				(13,688)		(207)		(72)				(13,967)	22
23	Inservice Training & Education													23
24	Travel and Seminar			90		824							914	24
25	Other Admin. Staff Transportation	(4,256)		445									(3,811)	25
26	Insurance-Prop.Liab.Malpractice			488		94							582	26
27	Other (specify):*				16,771	3,817							20,588	27
28	**TOTAL General Administration**	(112,226)	3,602	(117,568)	76,804	13,752	(207)		(72)				(135,915)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(113,562)	3,602	(114,173)	81,916	40,567			(530)				(102,180)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Park House Nursing & Rehab Ctr** **#** **0050740** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**74,609**	**42,820**	**2,638**		**498**							**120,565**	**30**
31	Amortization of Pre-Op. & Org.	**(338)**											**(338)**	**31**
32	Interest		**228,287**	**5,034**		**9,507**							**242,828**	**32**
33	Real Estate Taxes			**1,022**		**113**							**1,135**	**33**
34	Rent-Facility & Grounds		**(450,043)**	**702**									**(449,341)**	**34**
35	Rent-Equipment & Vehicles	**(417)**		**1,259**									**842**	**35**
36	Other (specify):*													**36**
37	**TOTAL Ownership**	**73,854**	**(178,936)**	**10,655**		**10,118**							**(84,309)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers							**(7,673)**	**(576)**				**(8,249)**	**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**							**(7,673)**	**(576)**				**(8,249)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(39,707)**	**(175,334)**	**(103,518)**	**81,916**	**50,685**		**(7,673)**	**(1,106)**				**(194,737)**	**45**

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				2320 S. Lawndale, LLC		Building Co.

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	34	Rental Income	$ 450,043	2320 S. Lawndale	100.00%	$	$ (450,043)	1
2	V	21	Administrative Expenses		2320 S. Lawndale	100.00%	150	150	2
3	V	21	Bank Service Fee		2320 S. Lawndale	100.00%	3,452	3,452	3
4	V	30	Depreciation Expense		2320 S. Lawndale	100.00%	42,820	42,820	4
5	V	32	Interest Expens		2320 S. Lawndale	100.00%	228,287	228,287	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 450,043			$ 274,709	$ * (175,334)	14

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

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 87	$ 87	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	243	243	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	313	313	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	710	710	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,042	2,042	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,447	1,447	20
21	V	19	Professional Fees	146,095	Extended Care Consulting, LLC	100.00%	6,032	(130,443)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,834	1,834	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	8,571	8,571	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	90	90	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	445	445	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	488	488	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,638	2,638	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	5,034	5,034	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,022	1,022	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	702	702	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,259	1,259	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 146,095			$ 32,957	$ * (103,518)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,380	$ 4,380	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	732	732	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	12	Admission (Direct)	25,500	Extended Care Consulting, LLC	100.00%	25,500		19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	5,619	5,619	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	68,102	68,102	22
23	V	21	Office and Clerical (Direct)	20,352	Extended Care Consulting, LLC	100.00%	20,352		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	12,319	12,319	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,452	4,452	25
26	V	22	Employee Benefits	13,688	Extended Care Consulting, LLC	100.00%		(13,688)	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			$ 59,540			$ 141,456	$ * 81,916	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 34	$ 34	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	73	73	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	72	72	17
18	V	19	Professional Fees	23,325	Extended Care Clinical, LLC	100.00%	4,042	(19,283)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	103	103	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	965	965	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	824	824	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	94	94	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	498	498	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	9,507	9,507	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	113	113	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	2,587	2,587	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	363	363	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	16,645	16,645	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	2,407	2,407	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	1,722	1,722	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,912	2,912	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	23,822	23,822	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	3,410	3,410	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	3,817	3,817	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,325			$ 74,010	$ * 50,685	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing Salary	6,154	Extended Care Clinical, LLC	100.00%	6,154		17
18	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%			18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	207	207	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	207	Extended Care Clinical, LLC	100.00%		(207)	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			$ 6,361			$ 6,361	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	39	Therapy	$ 16,350	TriCare Rehab	100.00%	$ 8,678	$ (7,673)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 16,350			$ 8,678	$ * (7,673)	39

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

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping		Xcel Supply, LLC	100.00%			16
17	V	4	Laundry	2,819	Xcel Supply, LLC	100.00%	2,631	(188)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	4,057	Xcel Supply, LLC	100.00%	3,787	(270)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits	1,078	Xcel Supply, LLC	100.00%	1,006	(72)	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	8,647	Xcel Supply, LLC	100.00%	8,071	(576)	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			$ 16,601			$ 15,495	$ * (1,106)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 57,583	$ 57,583	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	57,583	CCS Employee Benefits Group	100.00%		(57,583)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 57,583			$ 57,583	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Eric Rothner	Shareholder	Administrative	90.00%	See Attached	0.72	1.55%	Mgmt. Fees	$		1
2	Mark Steinberg	Relative	Administrative		See Attached	1.22	2.22%	Al. Salary/Fees	3,558	17-7	2
3	Adam Vales	Relative	Clerical		See Attached	0.3	0.75%	Alloc. Salary	529	22-7	3
4	G. Matt Silvers	Relative	Administrative		See Attached	0.03	0.13%	Alloc. Salary	99	17-7	4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										9
10	IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 4,186		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 Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	33,658	$ 87	1
2	02	Food	Patient Days	1,512,273	34	10,940		33,658	243	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		33,658	313	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		33,658	710	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		33,658	2,042	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		33,658	1,447	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		33,658	6,032	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		33,658	1,834	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		33,658	8,571	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		33,658	90	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		33,658	445	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		33,658	488	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		33,658	2,638	13
14	32	Interest	Patient Days	1,512,273	34	226,162		33,658	5,034	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		33,658	1,022	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		33,658	702	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		33,658	1,259	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 32,957	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	33,658	4,380	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		33,658	732	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607				4
5	12	Admission (Direct)	Direct		34	52,036	52,036		25,500	5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	33,658	5,619	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	33,658	68,102	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		20,352	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		33,658	12,319	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			4,452	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					$ 5,054,827	$ 4,364,695		$ 141,456	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	33,658	$ 34	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		33,658	73	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		33,658	72	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		33,658	4,042	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		33,658	103	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		33,658	965	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		33,658	824	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		33,658	94	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		33,658	498	9
10	32	Interest	Patient Days	1,512,273	34	427,165		33,658	9,507	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		33,658	113	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	33,658	2,587	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		33,658	363	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	33,658	16,645	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	33,658	2,407	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	33,658	1,722	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		33,658	2,912	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	33,658	23,822	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	33,658	3,410	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		33,658	3,817	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 74,010	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$	1
2	07	Emp. Ben. - General	Direct Allocation			1,662				2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		6,154	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597			4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			207	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 6,361	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	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	39	Therapy	Direct Allocation			$	$		$ 8,678	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	TOTALS					$	$		$ 8,678	25

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	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	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation							2
3	4	Laundry	Direct Allocation						2,631	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						3,787	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation						1,006	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						8,071	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					$	$		$ 15,495	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 57,583	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	TOTALS					$	$		$ 57,583	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Lake Forest		X				$	$ 2,295,178			$ 228,287	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	HFG		X	Line of Credit							(1,912)	6
7	First Bank		X								19,750	7
8	See Supplemental Schedule										14,541	8
9	TOTAL Facility Related						$	$ 2,295,178			$ 260,666	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 2,295,178			$ 260,666	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **None** Line # **N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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 Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Ext Care Conslt, LLC		X				$	$			$ 5,034	8
9	Alloc from Ext Care Clinical		X								9,507	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										14,541	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Park House Nursing & Rehab Ctr # 0050740 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	136,507	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.)	$	125,005	2
3. Under or (over) accrual (line 2 minus line 1).	$	(11,502)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,458	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.	$	3,000	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.	$	79,956	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	80,592	8
	2006	72,265	9
	2007	71,493	10
	2008	72,211	11
	2009	123,870	12

Allocation from Extended Care Consulting Building Alloc. $1,022

Allocation from Extended Care Clinical Building Alloc. $113

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park House Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050740

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-26-105-075-0000	Long Term Care Facility	$ 35,637.43	$ 35,637.43
2.	16-26-105-079-0000	Long Term Care Facility	$ 44,075.83	$ 44,075.83
3.	16-26-105-080-0000	Long Term Care Facility	$ 44,156.29	$ 44,156.29
4.	See Attached	Allocated from Main LLC	$ 116,500.56	$ 1,160.49
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 240,370.11	$ 125,030.04

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? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park House Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050740

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (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).

None

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			$ 40,650	1
2	Alloc. from Ext. Care Conslt/ Ext Care Clinical 2201 Main			8,169	2
3	TOTALS			$ 48,819	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1989		$ 1,209,350	$	39	$ 38,397	$ 38,397	$ 843,125	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	21,943		20			21,943	9
10	Various			1990	11,700		20	396	396	11,700	10
11	Various			1991	17,413		20	871	871	16,984	11
12	Various			1992	55,138		20	1,750	1,750	32,696	12
13	Various			1993	26,399		20	1,858	1,858	17,725	13
14	Various			1994	3,400		20	87	87	1,461	14
15	Various			1995	1,500		20	38	38	591	15
16	Various			1996	106,964		20	2,742	2,742	39,518	16
17	Various			1997	28,175		20	722	722	9,662	17
18	Various			1998	114,780		20	3,376	3,376	42,742	18
19	Various			1999	41,539		20	1,065	1,065	12,391	19
20	Various			2000	7,413		20	270	270	2,790	20
21	Various			2001	12,564		20	624	624	5,910	21
22	Various			2002	13,922		20	506	506	4,280	22
23	Various			2003	28,642		20	1,042	1,042	7,773	23
24	Various			2004	10,025		20	365	365	2,357	24
25	Various			2005	45,846		20	1,667	1,667	9,099	25
26	Various			2006	40,248		20	2,954	2,954	19,108	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											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 Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,209,350	42,820		31,009	(11,811)	843,125	67
68	Related Party Allocations (Pages 12H & 12I)		32,918	2,239		2,239		15,690	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 3,039,229	$ 45,059		$ 91,978	$ 46,919	$ 1,960,670	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,039,229	$ 45,059		$ 91,978	$ 46,919	$ 1,960,670	1
2	Heat Exchanger Rooftop Unit	2007	2,772		20	101	101	349	2
3	Painting Building	2007	2,560		20	93	93	322	3
4	Electrical Work	2007	9,020		20	328	328	1,134	4
5	Smoke & Exhaust Fans	2007	5,249		20	191	191	660	5
6	Compresson & Condensing Unit	2007	3,949		20	144	144	498	6
7	Wall Ac Units, Ceiling Tiles	2007	2,319		20	84	84	291	7
8	Cement Work	2007	2,100		20	76	76	263	8
9	Fence & Gates	2007	5,341		20	194	194	671	9
10	Heat Pump/ Sump Pump	2008	14,059		20	511	511	1,278	10
11	Replace Pipe & Sewer Line	2008	8,100		20	295	295	737	11
12	Wire Door To Alarm	2008	3,231		20	117	117	293	12
13	Bathroom Showers, Tubs, Sinks, Toilets, Tile	2009	128,320		20	2,139	2,139	4,278	13
14	Sprinkler Heads	2009	4,375		20	73	73	146	14
15	Roof Repair	2009	2,300		20	38	38	76	15
16	Electrical Work	2009	4,500		20	75	75	150	16
17	Carpet & Flooring	2009	8,300		20	139	139	278	17
18	Water Heater & Roof Exhaust	2009	6,909		20	115	115	230	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)		$ 3,252,633	$ 45,059		$ 96,691	$ 51,632	$ 1,972,324	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,252,633	$ 45,059		$ 96,691	$ 51,632	$ 1,972,324	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	TOTAL (lines 1 thru 33)		$ 3,252,633	$ 45,059		$ 96,691	$ 51,632	$ 1,972,324	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,252,633	$ 45,059		$ 96,691	$ 51,632	$ 1,972,324	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	TOTAL (lines 1 thru 33)		$ 3,252,633	$ 45,059		$ 96,691	$ 51,632	$ 1,972,324	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,252,633	$ 45,059		$ 96,691	$ 51,632	$ 1,972,324	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	TOTAL (lines 1 thru 33)		$ 3,252,633	$ 45,059		$ 96,691	$ 51,632	$ 1,972,324	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Facility	1989	1,209,350	42,820	39	31,009	(11,811)	843,125	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	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
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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 (12F & 12G lines 1 thru 33)		$ 1,209,350	$ 42,820		$ 31,009	$ (11,811)	$ 843,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting, 2201 Main LLC	2002	10,139	260	39	260		2,156	3
4	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,117	29	39	29		237	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	102	5	20	5		20	9
10	Allocated from Extended Care Consulting	2009	61	3	20	3		6	10
11	Allocated from Extended Care Consulting	2010	600	30	20	30		30	11
12									12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2002	8,376	765	20	765		5,366	13
14	Allocated from Extended Care Consulting, 2201 Main LLC	2003	9,871	902	20	902		6,323	14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2005	490	52	20	52		229	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2009	88	4	20	4		9	16
17									17
18	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	923	84	20	84		591	18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,087	99	20	99		697	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	54	6	20	6		25	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	10		20			1	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

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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 (12H & 12I lines 1 thru 33)		$ 32,918	$ 2,239		$ 2,239	$	$ 15,690	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 248,486	$ 502	$ 23,480	$ 22,978	10	$ 160,440	71
72	Current Year Purchases	325	32	32		10	32	72
73	Fully Depreciated Assets	220,896				10	220,896	73
74								74
75	TOTALS	$ 469,707	$ 534	$ 23,512	$ 22,978		$ 381,368	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From EC Consulting	2010	$ 7,157	$ 112	$ 112	$	5	$ 6,933	76
77		Allocated From EC Clinical	2010	1,244	249	249		5	581	77
78										78
79										79
80	TOTALS			$ 8,401	$ 361	$ 361	$		$ 7,514	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)	$ 3,779,560	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,954	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,563	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 74,609	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,361,206	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 Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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	Off Site Storage Rental				560			5
6	Allocated from Extended Care Consulting, LLC				702			6
7	TOTAL				$ 1,262 **			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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 17,864 Description: See Attached Schedule
(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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 - 03	hrs	$		$ 75,678	$		$ 75,678	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,792			4,792	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			58,756			58,756	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				99,645		99,645	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						37,170		37,170	13
14	TOTAL			$		$ 139,226	$ 136,815		$ 276,041	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Park House Nursing & Rehab Ctr **#** 0050740 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(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	$	$ 2,682	1
2	Cash-Patient Deposits	20,694	20,694	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,298,714	1,298,714	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,478	27,478	6
7	Other Prepaid Expenses	3,742	3,742	7
8	Accounts Receivable (owners or related parties)	(252,796)	(147,613)	8
9	Other(specify): See Attached Schedule	242,897	242,897	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,340,729	$ 1,448,594	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		40,650	13
14	Buildings, at Historical Cost		1,369,114	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		200,000	16
17	Accumulated Depreciation (book methods)		(1,134,831)	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): See Attached Schedule	2,700	2,700	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,700	$ 477,633	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,343,429	$ 1,926,227	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 674,700	$ 674,699	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,572	8,572	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,827	143,827	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,458	35,458	31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,458	88,458	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	298,029	547,412	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,249,044	$ 1,498,426	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,295,178	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,295,178	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,249,044	$ 3,793,604	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 94,385	$ (1,867,377)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,343,429	$ 1,926,227	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (68,013)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (68,013)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	162,398	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 162,398	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)**	$ 94,385	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,738,923	1
2	Discounts and Allowances for all Levels	(520,650)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,218,273	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	484,954	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 484,954	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	77,629	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,124	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,153	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 80,906	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		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)**	$ 4,784,133	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	829,857	31
32	Health Care	1,803,442	32
33	General Administration	1,092,738	33
	B. Capital Expense		
34	Ownership	561,622	34
	C. Ancillary Expense		
35	Special Cost Centers	276,041	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,621,735	40
41	**Income before Income Taxes (line 30 minus line 40)****	162,398	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 162,398	43

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

****** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

******** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2,013	2,149	$ 80,902	$ 37.65	1
2	Assistant Director of Nursing	1,855	2,646	72,748	27.49	2
3	Registered Nurses	9,573	10,316	274,405	26.60	3
4	Licensed Practical Nurses	13,243	14,394	350,661	24.36	4
5	CNAs & Orderlies	39,007	45,090	469,570	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,294	3,887	65,304	16.80	8
9	Activity Director	1,927	2,109	25,538	12.11	9
10	Activity Assistants	4,392	4,843	50,207	10.37	10
11	Social Service Workers	13,158	15,034	262,705	17.47	11
12	Dietician					12
13	Food Service Supervisor	2,029	2,244	42,648	19.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,650	15,758	155,505	9.87	15
16	Dishwashers					16
17	Maintenance Workers	3,851	4,226	66,094	15.64	17
18	Housekeepers	11,131	12,248	109,741	8.96	18
19	Laundry	3,742	4,303	42,550	9.89	19
20	Administrator	2,165	2,294	93,160	40.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,210	2,480	43,119	17.39	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	2,006	2,202	26,502	12.04	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	129,246	146,223	$ 2,231,359 *	$ 15.26	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	161	$ 8,581	01-03	35
36	Medical Director	Monthly	37,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,276	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	57	2,964	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	See Attached	800	31,862		47
48					48
49	TOTAL (lines 35 - 48)	1,018	$ 86,383		49

C. CONTRACT NURSES

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

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yechiel Mashiach	Administrator	0.00	$ 73,491
Mila Jeffrey	Administrator	0.00	19,669
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,160

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick, Bokor, Kagda	Accounting	$ 26,000
Denise Carnes	Accounting	683
Personnel Planners	Unemployment Consult	1,754
Prospect Resources	Natural Gas Procurement	3,000
Richard Peelo	Medicare Cost Report	4,800
Ron Cornaya	Accounting	500
Alan Sorscher	Accounting	500
Michigan Peer Review	Third Party Review	1,030
Extended Care Consulting	Home Office Expense	146,095
Extended Care Clinical	Home Office Expense	23,325
3 C Healthcare Consulting	Risk Management	2,545
See Supplemetal Schedule		55,101
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 265,334

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,956
Unemployment Compensation Insurance	62,331
FICA Taxes	161,422
Employee Health Insurance	109,831
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Emplyee Physicals	1,078
Pension Expense	22,512
Other Employee Welfare	1,102
Holiday Expense	882
Chicago Employer Taxes	2,630
TOTAL (agree to Schedule V, line 22, col.8)	$ 416,743

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	$ 2,284
Advertising: Employee Recruitment	4,069
Health Care Worker Background Check	3,276
(Indicate # of checks performed 273)	
Patient Background Checks	
Dues & Subscriptions	13
Licenses, Inspections & Permits	2,562
Advertising & Promotions	8,358
Alloc from Extended Care Consulting	1,834
See Supplemental Schedule	103
Less: Public Relations Expense	( )
Non-allowable advertising	(8,358)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,141

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,156
Allocated From EC Consulting	90
Allocated From EC Clinical	824
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,070

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr # 0050740 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Ctr **#** 0050740 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **N/A**

(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 Years**

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

(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. **N/A**

(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 **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
#0034991

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **58,035**
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. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **100% line 14**
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. $ **No**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **N/A**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.