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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0050740

Facility Name: Park House Nursing & Rehab Center

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: 12/16/09

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: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
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 01/01/12 to 12/31/12 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) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	5,124	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	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			3,833	3,833	8
9	SNF/PED					9
10	ICF	27,585	176	66	27,827	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,585	176	3,899	31,660	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.61%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 12/16/09

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/16/09 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 3,833

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: 12/31/12 Fiscal Year: 12/31/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	207,857	14,153	7,982	229,992		229,992	(26)	229,966			1
2	Food Purchase		158,689		158,689		158,689	315	159,004			2
3	Housekeeping	133,408	21,065		154,473		154,473	315	154,788			3
4	Laundry	45,849	6,623		52,472		52,472		52,472			4
5	Heat and Other Utilities			78,755	78,755		78,755	456	79,211			5
6	Maintenance	100,047		108,585	208,632		208,632	6,022	214,654			6
7	Other (specify):* See Supplemental	90,196			90,196		90,196	775	90,971			7
8	TOTAL General Services	577,357	200,530	195,322	973,209		973,209	7,857	981,066			8
	B. Health Care and Programs											
9	Medical Director			37,800	37,800		37,800		37,800			9
10	Nursing and Medical Records	1,251,395	51,002	5,304	1,307,701		1,307,701	(34)	1,307,667			10
10a	Therapy	89,307			89,307		89,307		89,307			10a
11	Activities	71,135	17,710	2,540	91,385		91,385		91,385			11
12	Social Services	270,159	25,587	6,375	302,121		302,121		302,121			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	1,681,996	94,299	52,019	1,828,314		1,828,314	(34)	1,828,280			16
	C. General Administration											
17	Administrative	203,510			203,510		203,510	11,078	214,588			17
18	Directors Fees											18
19	Professional Services			262,225	262,225		262,225	(136,211)	126,014			19
20	Dues, Fees, Subscriptions & Promotions			33,418	33,418		33,418	(15,137)	18,281			20
21	Clerical & General Office Expenses	96,851	18,493	344,041	459,385		459,385	(253,733)	205,652			21
22	Employee Benefits & Payroll Taxes			495,715	495,715		495,715	(3,387)	492,328			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,356	5,356		5,356	147	5,503			24
25	Other Admin. Staff Transportation			10,301	10,301		10,301	546	10,847			25
26	Insurance-Prop.Liab.Malpractice			91,595	91,595		91,595	644	92,239			26
27	Other (specify):* See Supplemental							15,232	15,232			27
28	TOTAL General Administration	300,361	18,493	1,242,651	1,561,505		1,561,505	(380,821)	1,180,684			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,559,714	313,322	1,489,992	4,363,028		4,363,028	(372,998)	3,990,030			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.

Park House Nursing & Rehab Center
Medicaid Cost Report
01/01/12 - 12/31/12

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	90,196		
Allocation - Extended Care Consulting: Emp. Ben.			775
Total	90,196	-	775
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Allocation - Extended Care Consulting: Emp. Ben.			15,232
Total	-	-	15,232

Park House Nursing & Rehab Center
Medicaid Cost Report
01/01/12 - 12/31/12

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Payee	Amount	Allowable
		-
Care Consultants of Illinois	6,617	6,617
Melissa Lindsay	3,665	3,665
Nicole Esposita Medina	19	19
		-
		-
		-
Alloc. - Extended Care Consulting	546	546
	10,847	10,847

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

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			5,105	5,105		5,105	4,582	9,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,433	3,433		3,433	(3,433)				32
33	Real Estate Taxes			128,782	128,782		128,782	(2,366)	126,416			33
34	Rent-Facility & Grounds			90,355	90,355		90,355	(90,355)				34
35	Rent-Equipment & Vehicles			23,493	23,493		23,493	705	24,198			35
36	Other (specify):* See Supplement											36
37	TOTAL Ownership			251,168	251,168		251,168	(90,867)	160,301			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,558	383,559	562,117		562,117	(828)	561,289			39
40	Barber and Beauty Shops			886	886		886		886			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,527	226,527		226,527		226,527			42
43	Other (specify):* See Supplement											43
44	TOTAL Special Cost Centers		178,558	610,972	789,530		789,530	(828)	788,702			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,559,714	491,880	2,352,132	5,403,726		5,403,726	(464,693)	4,939,033			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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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				9
10	Interest and Other Investment Income	(6,282)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	01		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	(3,785)	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	(309,900)	21		24
25	Fund Raising, Advertising and Promotional	(17,527)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,372)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(166,305)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (506,362)		$	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)	41,669		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,669		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (464,693)		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 Center

ID# 0050740

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RE Tax Refund Adustment	$ (3,811)	33	1
2	Other Income	(374)	21	2
3	Jury Income	(34)	10	3
4	Bank Charges	(8,850)	21	4
5	Theft Loss	(6,141)	21	5
6	Collection Expense	(204)	21	6
7	Non-Allowable Legal Expense	(24,967)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14	2320 South Lawndale, LLC			14
15	Prior Period Expenses	(37,224)	21	15
16	Interest Expense	(84,700)	32	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**	(166,305)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(191)	0	165	0	0	0	0	0	0	0	0	(26)	1
2	Food Purchase	0	0	315	0	0	0	0	0	0	0	0	315	2
3	Housekeeping	0	0	315	0	0	0	0	0	0	0	0	315	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	456	0	0	0	0	0	0	0	0	456	5
6	Maintenance	0	0	1,805	4,217	0	0	0	0	0	0	0	6,022	6
7	Other (specify):*	0	0	0	775	0	0	0	0	0	0	0	775	7
8	**TOTAL General Services**	(191)	0	3,056	4,992	0	0	0	0	0	0	0	7,857	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(34)	0	0	0	0	0	0	0	0	0	0	(34)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(34)	0	0	0	0	0	0	0	0	0	0	(34)	16
	C. General Administration													
17	Administrative	0	0	1,949	9,129	0	0	0	0	0	0	0	11,078	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(24,967)	0	(111,244)	0	0	0	0	0	0	0	0	(136,211)	19
20	Fees, Subscriptions & Promotions	(17,527)	0	2,390	0	0	0	0	0	0	0	0	(15,137)	20
21	Clerical & General Office Expenses	(368,850)	42,879	8,158	64,080	0	0	0	0	0	0	0	(253,733)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(3,387)	0	0	0	0	0	0	0	(3,387)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	147	0	0	0	0	0	0	0	0	147	24
25	Other Admin. Staff Transportation	0	0	546	0	0	0	0	0	0	0	0	546	25
26	Insurance-Prop.Liab.Malpractice	0	0	644	0	0	0	0	0	0	0	0	644	26
27	Other (specify):*	0	0	0	15,232	0	0	0	0	0	0	0	15,232	27
28	**TOTAL General Administration**	(411,344)	42,879	(97,410)	85,054	0	0	0	0	0	0	0	(380,821)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(411,569)	42,879	(94,354)	90,046	0	0	0	0	0	0	0	(372,998)	29

STATE OF ILLINOIS

Summary B

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

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	0	0	4,582	0	0	0	0	0	0	0	0	4,582	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(90,982)	84,700	2,849	0	0	0	0	0	0	0	0	(3,433)	32
33	Real Estate Taxes	(3,811)	0	1,445	0	0	0	0	0	0	0	0	(2,366)	33
34	Rent-Facility & Grounds	0	(90,355)	0	0	0	0	0	0	0	0	0	(90,355)	34
35	Rent-Equipment & Vehicles	0	0	705	0	0	0	0	0	0	0	0	705	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(94,793)	(5,655)	9,581	0	0	0	0	0	0	0	0	(90,867)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(172)	(656)	0	0	0	0	(828)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(172)	(656)	0	0	0	0	(828)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(506,362)	37,224	(84,773)	90,046	0	(172)	(656)	0	0	0	0	(464,693)	45

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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	Rent	$ 90,355	2320 South Lawndale, LLC	100.00%	$	$ (90,355)	1
2	V	21	Prior Period Expenses		2320 South Lawndale, LLC	100.00%	42,879	42,879	2
3	V	32	Interest		2320 South Lawndale, LLC	100.00%	84,700	84,700	3
4	V	33	Real Estate Taxes	120,419	2320 South Lawndale, LLC	100.00%	120,419		4
5	V								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			$ 210,774			$ 247,998	$ * 37,224	14

*** 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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Eric Rothner	90.00%	Avenue Care Nursing and Rehab	Chicago, IL	Ext. Care Consult.	Evanston, IL	Home Office	1
2	Rothner Family Grandchildren Trust	10.00%	Beecher Manor Nursing and Rehab	Beecher, IL	Ext. Care Clinical	Evanston, IL	Administrative	2
3			Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Grasmere Place	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL				10
11			Snow Vally Nursing and Rehab	Lisle, IL				11
12			South Suburban Rehabilitation Center	Chicago, IL	2320 South			12
13			Tri-State Nursing and Rehab	Lansing, IL	Lawndale, LLC	Chicago, IL	Bldg. Company	13
14			Wheaton Care Center	Wheaton, IL				14
15			Boulevard Care Nursing and Rehab	Chicago, IL				15
16			Countryside Nursing and Rehab	Dolton, IL				16
17			Hillcrest Nursing and Rehab	Joliet, IL				17
18			Oak Park Healthcare Center	Oak Park, IL				18
19			Park House Nursing and Rehab	Chicago, IL				19
20			Timber Point Healthcare Center	Camp Point, IL				20
21			Prairie Village Healthcare Center	Jacksonville, IL				21
22			Dyer Nursing and Rehab	Dyer, IN				22
23			Lake County Nursing and Rehab	East Chicago, IN				23
24			Sebos Nursing and Rehab	Holbart, IN				24
25			Sheffield Manor Nursing Center	Indianapolis, IN				25
26			McKinley Health Care Center	Canton, OH				26
27			Homestead Nursing and Rehab	Lincoln, NE				27
28			Lancaster Manor	Lincoln, NE				28
29			Golden Plaines	Hutchinson, KS				29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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

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%	$ 165	$ 165	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	315	315	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	315	315	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	456	456	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,805	1,805	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,949	1,949	20
21	V	19	Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	2,756	(111,244)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,390	2,390	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	8,158	8,158	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	147	147	24
25	V	25	Other Staff Admin. Transport.		Extended Care Consulting, LLC	100.00%	546	546	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	644	644	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	4,582	4,582	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	2,849	2,849	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,445	1,445	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	705	705	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			$ 114,000			$ 29,227	$ * (84,773)	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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$	Extended Care Consulting, LLC	100.00%	$ 4,217	$ 4,217	15
16	V	06	Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%	775	775	17
18	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%			18
19	V	10	Nursing		Extended Care Consulting, LLC	100.00%			19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	9,129	9,129	20
21	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	64,080	64,080	21
22	V	21	Office and Clerical	15,724	Extended Care Consulting, LLC	100.00%	15,724		22
23	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	13,451	13,451	23
24	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	1,781	1,781	24
25	V	22	Employee Benefits	3,387	Extended Care Consulting, LLC	100.00%		(3,387)	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			$ 19,111			$ 109,157	$ * 90,046	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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Health Insurance	$ 68,483	CCS VEBA	100.00%	$ 68,483	$	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			$ 68,483			$ 68,483	$ *	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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$	Care Centers Health Systems, Inc.	100.00%	$	$	15
16	V	10	Nursing		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary	614	Care Centers Health Systems, Inc.	100.00%	442	(172)	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			$ 614			$ 442	$ * (172)	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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Ancillary	$ 375,905	Tricare Rehab	100.00%	$ 375,249	$ (656)	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			$ 375,905			$ 375,249	$ * (656)	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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Adam Vales	Relative	Clerical	0	See Attached	0.17	0.04%	Alloc. Sal	$ 302	22 - 7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 302		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 - 3000
Fax Number: (847) 491 - 9565

	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	1,364,178	31	$ 7,101	$	31,660	$ 165	1
2	02	Food	Patient Days	1,364,178	31	13,586		31,660	315	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		31,660	315	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		31,660	456	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		31,660	1,805	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		31,660	1,949	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		31,660	2,756	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		31,660	2,390	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		31,660	8,158	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		31,660	147	10
11	25	Other Staff Admin. Transpor.	Patient Days	1,364,178	31	23,506		31,660	546	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		31,660	644	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		31,660	4,582	13
14	32	Interest	Patient Days	1,364,178	31	122,765		31,660	2,849	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		31,660	1,445	15
16	35	Rent - Equipment and Auto	Patient Days	1,364,178	31	30,363		31,660	705	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 29,227	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 - 3000
Fax Number: (847) 491 - 9565

	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	Patient Days	1,364,178	31	$ 181,713	$ 181,713	31,660	$ 4,217	1
2	06	Maintenance	Direct Allocation	1	1			1		2
3	07	Employee Benefits	Patient Days	1,364,178	31	33,386		31,660	775	3
4	07	Employee Benefits	Direct Allocation	1	1			1		4
5	17	Administrative	Patient Days	1,364,178	31	393,362	393,362	31,660	9,129	5
6	21	Office and Clerical	Patient Days	1,364,178	31	2,761,089	2,761,089	31,660	64,080	6
7	21	Office and Clerical	Direct Allocation	1	1	15,724	15,724	1	15,724	7
8	27	Employee Benefits	Patient Days	1,364,178	31	579,570		31,660	13,451	8
9	27	Employee Benefits	Direct Allocation	1	1	1,781		1	1,781	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					$ 3,966,625	$ 3,351,888		$ 109,157	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 VEBA
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 - 3000
Fax Number: (847) 491 - 9565

	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	Health Insurance	Direct Allocation	1	1	$ 68,483	$	1	$ 68,483	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					$ 68,483	$		$ 68,483	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: Care Centers Health Systems, Inc.
Street Address: 200 Howard Avenue #246
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: ((224) 612 - 5662
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	Dietary	Profit Margin %	167,706	21	$ 120,751	$		$	1
2	10	Nursing	Profit Margin %	4,037	21	2,907				2
3	39	Ancillary	Profit Margin %	177,899	21	128,090		614	442	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					$ 251,748	$		$ 442	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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, Illinois 60162
Phone Number: (708) 449 - 9400
Fax Number: (708) 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	Ancillary	Profit Margin %	10,092,326	17	$ 10,074,726	$	375,905	$ 375,249	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					$ 10,074,726	$		$ 375,249	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit							3,433	6
7	Alloc. - Extended Care	X		Line of Credit							2,849	7
8												8
9	TOTAL Facility Related						$	$			$ 6,282	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Interest Income		X								(6,282)	13
14	TOTAL Non-Facility Related						$	$			$ (6,282)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 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 Center **#** 0050740 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 135,725	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.)		$ 130,170	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,555)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 135,161	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.)**		$ 8,363	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** $ 14,742 **For** 09 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (11,553)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 126,416	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	71,493	8
	2008	72,211	9
	2009	123,870	10
	2010	129,262	11
	2011	128,725	12

2012 Real Estate Tax Accrual = $128,725 * 1.05 = $135,161

Extended Care Consulting, LLC (Allocation) - $1,445

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park House Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050740

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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	$ 37,034.21	$ 37,034.21
2.	16-26-105-079-0000	Long Term Care Facility	$ 45,803.34	$ 45,803.34
3.	16-26-105-080-0000	Long Term Care Facility	$ 45,886.97	$ 45,886.97
4.	Allocation	Extended Care Consulting, LLC	$ 127,119.67	$ 1,148.30
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 255,844.19	$ 129,872.82

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

Park House Nursing & Rehab Center
Medicaid Cost Report
01/01/12 - 12/31/12

Page 10 Supplemental Schedule

Vendor	Description		Amount
Appeal Costs			
Finkel, Martwick & Colson, P.C.	2009 Real Estate Taxes		3,857
Finkel, Martwick & Colson, P.C.	2011 Real Estate Taxes		1,756
First Real Estate Services, Ltd.	Appraisal Services		2,750
Total - Line 5 Total			8,363
Refunds			
Cook County	2009 Real Estate Tax Refund		14,742
Total			14,742
Refund Adjustment			
Appeal Costs			8,363
Real Estate Tax Refund		14,742	
Appeal Costs		8,363	
Remainder		6,378	
1/2 of Remainder			3,189
Total - Line 6 Total			11,553

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior Brick Frame Steel 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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 40,650	1
2	Ext. Care Consult.			7,407	2
3	TOTALS			$ 48,057	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1989		$ 1,209,350	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	21,943						9
10	Various			1990	11,700						10
11	Various			1991	17,413						11
12	Various			1992	55,138						12
13	Various			1993	26,399						13
14	Various			1994	3,400						14
15	Various			1995	1,500						15
16	Various			1996	106,964						16
17	Various			1997	28,175						17
18	Various			1998	114,780						18
19	Various			1999	41,539						19
20	Various			2000	7,413						20
21	Various			2001	12,564						21
22	Various			2002	13,922						22
23	Various			2003	28,642						23
24	Various			2004	10,025						24
25	Various			2005	45,846						25
26	Various			2006	40,248						26
27	Various			2007	33,310						27
28	Various			2008	25,390						28
29	Bathroom Showers, Tubs, Sinks, Toilets and Tile			2009	128,320						29
30	Spinkler Heads			2009	4,375						30
31	Roof Repair			2009	2,300						31
32	Electrical Work			2009	4,500						32
33	Carpet and Flooring			2009	8,300						33
34	Water Heater and Roof Exhaust			2009	6,909						34
35	Six Delay Egress Doors			2011	8,534						35
36	Two Temperature Control Compressors - Installation			2011	4,630						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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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									67
68	Financial Statement Depreciation			1,353		1,353		1,798	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,023,529	$ 1,353		$ 1,353	$	$ 1,798	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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,023,529	$ 1,353		$ 1,353	$	$ 1,798	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Allocations - Extended Care Consulting	2007	107	5	20	5		32	5
6	Allocations - Extended Care Consulting	2009	96	3	20	3		13	6
7	Allocations - Extended Care Consulting	2010	937	31	20	31		94	7
8	Allocations - Extended Care Consulting	2011	337	11	20	11		23	8
9	Allocations - Extended Care Consulting	2012	111	4	20	4		4	9
10									10
11	Allocations - Extended Care Consulting / 2201 Main LLC	2002	10,207	262	39	262		2,694	11
12	Allocations - Extended Care Consulting / 2201 Main LLC	2002	8,432	771	10	771		6,943	12
13	Allocations - Extended Care Consulting / 2201 Main LLC	2003	9,937	908	10	908		8,182	13
14	Allocations - Extended Care Consulting / 2201 Main LLC	2005	494	52	10	52		335	14
15	Allocations - Extended Care Consulting / 2201 Main LLC	2009	89	4	10	4		18	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)		$ 2,054,276	$ 3,404		$ 3,404	$	$ 20,136	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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 16,817	$ 3,363	$ 3,363	$	5 - 7	$ 5,110	71
72	Current Year Purchases	2,334	389	389		5	389	72
73	Fully Depreciated Assets							73
74	See Supplemental	295,869	1,812	1,812			293,142	74
75	TOTALS	$ 315,020	$ 5,564	$ 5,564	$		$ 298,641	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	Alloc. - Extended Care			3,597	719	719		5	3,597	77
78										78
79										79
80	TOTALS			$ 3,597	$ 719	$ 719	$		$ 3,597	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)	$ 2,420,950	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,687	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 9,687	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 322,374	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.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Park House Nursing & Rehab Center
Medicaid Cost Report
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Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - 2320 S. Lawndale, LLC			
Prior	200,000	-	200,000
Current			
Total	200,000	-	200,000
Related Party 2 - Extended Care Consulting			
Prior	2,399	240	918
Current	65,782		65,782
Total	68,181	240	66,700
Related Party 3 - Extended Care Consulting / 2201 Mail LLC			
Prior	2,827	283	2,794
Current			
Total	2,827	283	2,794
Related Party 4 - Extended Care Consulting - Matrix Software			
Prior	24,861	1,289	23,648
Current			
Total	24,861	1,289	23,648
Total	**295,869**	**1,812**	**293,142**

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 19,545 Description: See Supplemental 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	Facility	Various	$	$ 4,653	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,653	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

Park House Nursing & Rehab Center
Medicaid Cost Report
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Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Description	Amount
Total		-

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Description	Amount
GE Captial	Copier	9,075
Hughes Enterprises	Medical Equipment	8,220
Global Medical Products	Medical Equipment	1,166
Chicago Office Technology		37
Care Consultants of Illinois		280
Extended Care Consultants		62
Alloc. - Extended Care Consulting		705
Total		19,545

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

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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 226,304	$		$ 226,304	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,126			1,126	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			148,475			148,475	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				163,735		163,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					14,823		14,823	12
13	Other (specify): See Supplemental	39 - 03				7,654			7,654	13
14	TOTAL			$		$ 383,559	$ 178,558		$ 562,117	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

Park House Nursing & Rehab Center
Medicaid Cost Report
01/01/12 - 12/31/12

Page 16 Supplemental Schedule

Description	Supplies	Other
Food Pump	1,603	
Laboratory		3,780
Low Pressure Mattresses	457	
Medical Supplies	2,143	
Other Services	3,254	658
Oxygen	5,454	
Radiology		3,216
Therapy and Rehab Supplies	1,396	
Wheelchairs and Walkers	516	
Total	14,823	7,654

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 1,004	$ 2,238	1
2	Cash-Patient Deposits	17,234	17,234	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 252,297)	1,322,709	1,322,709	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,349	53,349	6
7	Other Prepaid Expenses	100,154	100,154	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,494,450	$ 1,495,684	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		31,174	13
14	Buildings, at Historical Cost		890,201	14
15	Leasehold Improvements, at Historical Cost	13,164	172,910	15
16	Equipment, at Historical Cost	19,151	219,151	16
17	Accumulated Depreciation (book methods)	(7,297)	(1,331,682)	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 Supplemental			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,018	$ (18,246)	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,519,468	$ 1,477,438	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,112,121	$ 1,112,121	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,026	8,026	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,622	133,622	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,461	5,461	31
32	Accrued Real Estate Taxes(Sch.IX-B)		135,161	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	139,102	2,275,490	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,398,332	$ 3,669,881	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,398,332	$ 3,669,881	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 121,136	$ (2,192,443)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,519,468	$ 1,477,438	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Total	-	-
Line 23 - Other Long Term Assets		
Total	-	-
Line 36 - Other Current Liabilities		
Due to Related Parties	139,102	2,275,490
Total	139,102	2,275,490
Line 43 - Other Long Term Liabilities		
Total	-	-

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 838,131	1
2	Restatements (describe):		2
3	**Prior Period Accounting Adjustments**	(20,690)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 817,441	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	303,695	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,000,000)	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)**	$ (696,305)	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)**	$ 121,136	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,508,656	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,508,656	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,480	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 7,480	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,899	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,899	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	175,386	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 175,386	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,707,421	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	973,209	31
32	Health Care	1,828,314	32
33	General Administration	1,561,505	33
	B. Capital Expense		
34	Ownership	251,168	34
	C. Ancillary Expense		
35	Special Cost Centers	563,003	35
36	Provider Participation Fee	226,527	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,403,726	40
41	**Income before Income Taxes (line 30 minus line 40)****	303,695	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 303,695	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,625,043	44
45	Private Pay - Net Inpatient Revenue	22,806	45
46	Medicare - Net Inpatient Revenue	1,852,118	46
47	Other-(specify) Hospice - Net Patient Service Revenue	8,689	47
48	Other-(specify) Insurance - Net Patient Service Revenue		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,508,656	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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Description	Total	Adjustment
Line 28 - Other Revenue		
PP Income and Expense Adjustments	174,978	
Other Income	374	374
Jury Duty Reimbursement	34	34
Total	175,386	408

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,982	2,274	$ 100,563	$ 44.22	1
2	Assistant Director of Nursing	1,889	2,364	74,642	31.57	2
3	Registered Nurses	6,017	6,838	197,227	28.84	3
4	Licensed Practical Nurses	14,354	15,402	388,160	25.20	4
5	CNAs & Orderlies	39,279	43,831	462,297	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,875	4,655	89,307	19.19	8
9	Activity Director	1,905	2,103	27,645	13.15	9
10	Activity Assistants	4,224	4,690	43,490	9.27	10
11	Social Service Workers	13,249	14,576	270,159	18.53	11
12	Dietician					12
13	Food Service Supervisor	1,921	2,134	45,526	21.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,973	4,608	48,969	10.63	15
16	Dishwashers	9,962	11,273	113,362	10.06	16
17	Maintenance Workers	5,844	6,181	100,047	16.19	17
18	Housekeepers	12,392	13,714	133,408	9.73	18
19	Laundry	3,965	4,439	45,849	10.33	19
20	Administrator	1,961	2,141	103,549	48.36	20
21	Assistant Administrator	2,718	3,156	72,388	22.94	21
22	Other Administrative	382	382	27,573	72.18	22
23	Office Manager					23
24	Clerical	3,120	3,534	96,851	27.41	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	1,966	2,166	28,506	13.16	31
32	Other Health Care(specify)					32
33	Other(specify) Security	9,621	10,165	90,196	8.87	33
34	TOTAL (lines 1 - 33)	144,599	160,626	$ 2,559,714 *	$ 15.94	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		$ 7,982	01 - 03	35
36	Medical Director		37,800	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,304	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		2,540	11 - 03	44
45	Social Service Consultant		6,375	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 60,001		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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Lindsay	Administrator	0	$ 103,549
Lorena Robledo-Sommerfield	Administration	0	64,085
Sherwin Ray	Administration	0	8,303
Sherwin Ray	Administration	0	27,573
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 203,510

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
Extended Care Consulting	Home Office	$ 114,000
Krupnick, Bokor, Kagda	Accounting	1,650
Plante & Moran, PLLC	Accounting	26,850
Personnel Planners	Unemployment Consultant	1,436
Blymas, Inc.	Other Professional	2,326
Extended Care Consulting	Other Professional	1,566
Prospect Resources, Inc.	Other Professional	1,500
HFG	Other Professional	8,139
Other	Other Professional	507
OmniCare of Northern Illinois	Computer Maintenance	420
Care Consultants of Illinois	Computer Maintenance	20,500
See Supplemental Schedule		83,331
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 262,225

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,319
Unemployment Compensation Insurance	96,684
FICA Taxes	187,870
Employee Health Insurance	68,483
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	347
Other Employee Welfare	1,090
Holiday Expense	1,808
Pension	19,727
TOTAL (agree to Schedule V, line 22, col.8)	$ 492,328

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,349
Health Care Worker Background Check	9,005
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	168
Licenses and Fees	5,369
Advertising and Promotion	17,527
Alloc. - Extended Care Consulting	2,390
Less: Public Relations Expense	( )
Non-allowable advertising	(17,527)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,281

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,356
Alloc. - Extended Care Consulting	147
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,503

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Comcast Cable	Computer Maintenance	1,057
American Data	Data Processing	4,184
E-Health Data Solutions	Data Processing	5,445
MDI Achieve	Data Processing	14,551
Paycor	Data Processing	10,141
Care Consultants of Illinois	Data Processing	898
Extended Care Consulting	Data Processing	3,970
Medifax-EDI, LLC	Data Processing	551
National Datacare Corporation	Data Processing	2,970
Nebo Systems, Inc.	Data Processing	57
Pro Payroll Solutions	Data Processing	3,393
Other	Data Processing	393
Ashman & Stein	Legal	4,305
Burke, Warren, MacKay & Serritella, P.C.	Legal	4,042
Chuhak & Tecson, P.C.	Legal	2,879
Deutsch, Levy & Engel	Legal	5,624
Extended Care Consulting	Legal	785
Schueler, Dallavo & Casieri	Legal	2,770
Finkel, Martwick & Colson	Legal	3,857
Grabowski Law Center, LLC	Legal	204
Jackson Lewis, LLP	Legal	3,198
Law Offices of Evelyn Hoff	Legal	1,800
Meyer Magence	Legal	2,332
Schoenberg, Finkel, Newman	Legal	2,250
Williams, Montgomery & John, Ltd.	Legal	1,675
Total		83,331

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Page 21 Supplemental Schedule - Legal Details

Vendor	Invoice Date	Amount	Allowable
Ashman & Stein	04/23/12	163	
Ashman & Stein	04/23/12	3,135	
Ashman & Stein	04/23/12	184	
Ashman & Stein	06/12/12	574	
Ashman & Stein	09/24/12	22	
Ashman & Stein	11/20/12	228	
Burke, Warren, MacKay & Serritella, P.C.	01/31/12	941	
Burke, Warren, MacKay & Serritella, P.C.	02/29/12	352	
Burke, Warren, MacKay & Serritella, P.C.	03/30/12	107	
Burke, Warren, MacKay & Serritella, P.C.	04/30/12	253	
Burke, Warren, MacKay & Serritella, P.C.	05/31/12	36	
Burke, Warren, MacKay & Serritella, P.C.	07/31/12	40	
Burke, Warren, MacKay & Serritella, P.C.	08/31/12	280	
Burke, Warren, MacKay & Serritella, P.C.	09/30/12	838	
Burke, Warren, MacKay & Serritella, P.C.	10/26/12	150	
Burke, Warren, MacKay & Serritella, P.C.	11/23/12	585	
Burke, Warren, MacKay & Serritella, P.C.	12/21/12	462	
Chuhak & Tecson, P.C.	01/31/12	21	
Chuhak & Tecson, P.C.	01/31/12	180	
Chuhak & Tecson, P.C.	01/31/12	21	
Chuhak & Tecson, P.C.	01/31/12	148	
Chuhak & Tecson, P.C.	04/30/12	1,371	
Chuhak & Tecson, P.C.	04/30/12	76	
Chuhak & Tecson, P.C.	04/30/12	483	
Chuhak & Tecson, P.C.	05/31/12	99	
Chuhak & Tecson, P.C.	07/31/12	333	
Chuhak & Tecson, P.C.	09/24/12	63	
Chuhak & Tecson, P.C.	08/31/12	37	
Chuhak & Tecson, P.C.	09/24/12	5	
Chuhak & Tecson, P.C.	09/30/12	42	
Deutsch, Levy & Engel	02/29/12	378	
Deutsch, Levy & Engel	02/29/12	1,995	
Deutsch, Levy & Engel	03/28/12	3,109	
Deutsch, Levy & Engel	04/23/12	143	
Extended Care Consulting	09/28/12	256	
Extended Care Consulting	11/28/12	21	
Extended Care Consulting	12/21/12	469	
Extended Care Consulting	04/30/12	42	
Schueler, Dallavo & Casieri	09/19/12	2,770	2,770
Finkel, Martwick & Colson	11/30/12	3,857	
Grabowski Law Center, LLC	12/31/12	204	204
Jackson Lewis, LLP	09/24/12	3,016	3,016
Jackson Lewis, LLP	09/28/12	182	182
Law Offices of Evelyn Hoffman, LLC	01/31/12	1,800	
Meyer Magence	01/31/12	2,332	2,332
Schoenberg, Finkel, Newman	10/31/12	2,250	2,250
Williams, Montgomery & John, Ltd.	02/22/12	1,367	
Williams, Montgomery & John, Ltd.	02/22/12	291	
Williams, Montgomery & John, Ltd.	02/22/12	14	
			-
		35,721	10,754
Page 5 Adjustments			24,967

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Page 21 Supplemental Schedule - Seminar

Vendor	Invoice Date	Amount	Allowable
Care Consultants of Illinois	03/31/12	150	150
Care Consultants of Illinois	05/31/12	185	185
DKG Media, LP	10/23/12	299	299
Illinois Council on Long Term Care	02/14/12	325	325
Illinois Council on Long Term Care	04/18/12	230	230
Illinois Council on Long Term Care	08/31/12	495	495
Illinois Council on Long Term Care	10/23/12	495	495
Illinois Council on Long Term Care	11/30/12	100	100
Illinois Council on Long Term Care	12/21/12	1,000	1,000
Melissa Lindsay	04/18/12	50	50
Pathway Health Services	01/19/12	1,500	1,500
Care Consultants of Illinois	09/19/12	332	332
Care Consultants of Illinois	12/31/12	195	195
			-
Alloc. - Extended Care Consulting		147	147
		5,503	5,503
Page 5 Adjustments			-

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

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 Center # 0050740 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Yrs**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **226,527**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **0** 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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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