

Facility Name & ID Number Abbott House

0023739 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>106</u>	Intermediate (ICF)	<u>106</u>	<u>38,796</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,796</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>32,770</u>	<u>2,128</u>	<u>1,253</u>	<u>36,151</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,770</u>	<u>2,128</u>	<u>1,253</u>	<u>36,151</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.18%

D. How many bed-hold days during this year were paid by the Department? 543 (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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 12/15/77

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

Facility Name & ID Number Abbott House # 0023739 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	288,698	27,026	7,404	323,128		323,128		323,128		1
2	Food Purchase		232,306		232,306		232,306	(137)	232,169		2
3	Housekeeping	170,183	28,360		198,543		198,543		198,543		3
4	Laundry	53,018	4,745		57,763		57,763		57,763		4
5	Heat and Other Utilities			64,344	64,344		64,344	341	64,685		5
6	Maintenance	113,456	26,460	75,655	215,571		215,571	(13,612)	201,959		6
7	Other (specify):*										7
8	TOTAL General Services	625,355	318,897	147,403	1,091,655		1,091,655	(13,408)	1,078,247		8
	B. Health Care and Programs										
9	Medical Director			3,400	3,400		3,400		3,400		9
10	Nursing and Medical Records	811,621	47,809	12,884	872,314		872,314	(14,409)	857,905		10
10a	Therapy		57	4,125	4,182		4,182		4,182		10a
11	Activities	95,285	20,595	8,309	124,189		124,189		124,189		11
12	Social Services	201,154			201,154		201,154		201,154		12
13	CNA Training										13
14	Program Transportation			1,835	1,835		1,835		1,835		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,108,060	68,461	30,553	1,207,074		1,207,074	(14,409)	1,192,665		16
	C. General Administration										
17	Administrative	167,087		425,624	592,711		592,711	(272,939)	319,772		17
18	Directors Fees										18
19	Professional Services			111,256	111,256		111,256	470	111,726		19
20	Dues, Fees, Subscriptions & Promotions			60,900	60,900		60,900	(47,574)	13,326		20
21	Clerical & General Office Expenses	155,548	62,584	167,147	385,279		385,279	(130,603)	254,676		21
22	Employee Benefits & Payroll Taxes			383,286	383,286		383,286	(29,189)	354,097		22
23	Inservice Training & Education										23
24	Travel and Seminar			27,707	27,707		27,707	(21,555)	6,152		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			55,447	55,447		55,447	26	55,473		26
27	Other (specify):*							45,143	45,143		27
28	TOTAL General Administration	322,635	62,584	1,231,367	1,616,586		1,616,586	(456,222)	1,160,364		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,056,050	449,942	1,409,323	3,915,315		3,915,315	(484,039)	3,431,276		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 Abbott House

#0023739

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			31,842	31,842		31,842	36,600	68,442			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,809	4,809		4,809	(4,809)				32
33	Real Estate Taxes			44,338	44,338		44,338		44,338			33
34	Rent-Facility & Grounds			423,520	423,520		423,520	(406,322)	17,198			34
35	Rent-Equipment & Vehicles			3,860	3,860		3,860	974	4,834			35
36	Other (specify):*											36
37	TOTAL Ownership			508,369	508,369		508,369	(373,557)	134,812			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		36,695		36,695		36,695	(36,695)				41
42	Provider Participation Fee			445,493	445,493		445,493		445,493			42
43	Other (specify):*			387	387		387	(387)				43
44	TOTAL Special Cost Centers		36,695	445,880	482,575		482,575	(37,082)	445,493			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,056,050	486,637	2,363,572	4,906,259		4,906,259	(894,677)	4,011,582			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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	54,003	30		9
10	Interest and Other Investment Income	(4,367)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(137)	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				18
19	Entertainment				19
20	Contributions	(9,668)	20		20
21	Owner or Key-Man Insurance	(10,187)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,876)	21		24
25	Fund Raising, Advertising and Promotional	(28,314)	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	(241,274)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (270,819)		\$	30

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	2	
		Amount	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)	(623,858)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (623,858)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (894,677)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Abbott House

	ID#	0023739
Report Period Beginning:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Expense	\$ (36,695)	41	1
2	Personal Reimbursement - Auto	(7,315)	17	2
3	Misc. Income	(4,061)	21	3
4	Veterans Expenses	(14,409)	10	4
5	Bank Charges	(11,375)	21	5
6	Marketing Consultant	(387)	43	6
7	Open House Expense	(26,489)	21	7
8	Trust Fees	(100)	21	8
9	Bank Charges - Bldg. Co	(63)	21	9
10	State Replacement Tax - Bldg. Co	(5,028)	21	10
11	Accounting Fees - Bldg. Co.	(4,975)	19	11
12	Non-Care Depreciation	(30,682)	30	12
13	Additional R&Ms	6,273	06	13
14	Capitalized R&M	(19,885)	06	14
15	Out of Period Legal Fees	(149)	19	15
16	Non-Allowable Expense	(6,719)	21	16
17	Out of State Seminars	(21,555)	24	17
18	PPA - Other Fees	(39,475)	21	18
19	Non-Allowable Expense	(8,593)	21	19
20	Alliance for Living PAC Dues	(9,592)	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	(241,274)		49

Abbott House

Report Period Beginning: ID# 0023739
 Ending: 01/01/12
 12/31/12

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 Abbott House# 0023739

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(137)											(137)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			341									341	5
6	Maintenance	(13,612)											(13,612)	6
7	Other (specify):*													7
8	TOTAL General Services	(13,749)		341									(13,408)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(14,409)											(14,409)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(14,409)											(14,409)	16
	C. General Administration													
17	Administrative	(7,315)		(26,000)	(81,500)	(158,124)							(272,939)	17
18	Directors Fees													18
19	Professional Services	(5,124)	4,975	525		94							470	19
20	Fees, Subscriptions & Promotions	(47,574)											(47,574)	20
21	Clerical & General Office Expenses	(132,779)	5,091	(2,915)									(130,603)	21
22	Employee Benefits & Payroll Taxes	(10,187)		(19,002)									(29,189)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(21,555)											(21,555)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			26									26	26
27	Other (specify):*			18,149	18,437	8,557							45,143	27
28	TOTAL General Administration	(224,534)	10,066	(29,218)	(63,063)	(149,473)							(456,222)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(252,692)	10,066	(28,877)	(63,063)	(149,473)							(484,039)	29

STATE OF ILLINOIS

Facility Name & ID Number Abbott House# 0023739

Report Period Beginning:

01/01/12

Ending:

Summary B

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	23,321	13,260	19									36,600	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,367)	(442)										(4,809)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(420,000)	13,678									(406,322)	34
35	Rent-Equipment & Vehicles			974									974	35
36	Other (specify):*													36
37	TOTAL Ownership	18,954	(407,182)	14,671									(373,557)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(36,695)											(36,695)	41
42	Provider Participation Fee													42
43	Other (specify):*	(387)											(387)	43
44	TOTAL Special Cost Centers	(37,082)											(37,082)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(270,819)	(397,116)	(14,206)	(63,063)	(149,473)							(894,677)	45

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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 420,000	Abbott House Realty, LLC	100.00%	\$	\$ (420,000)	1
2	V	33 R/E Tax Income	54,000	Abbott House Realty, LLC	100.00%		(54,000)	2
3	V	33 R/E Tax Reimb. Prior Year	9,662	Abbott House Realty, LLC	100.00%	9,662		3
4	V	33 R/E Taxes		Abbott House Realty, LLC	100.00%	54,000	54,000	4
5	V	21 Annual Filing Fee		Abbott House Realty, LLC	100.00%			5
6	V	19 Accounting Fee		Abbott House Realty, LLC	100.00%	4,975	4,975	6
7	V	30 Depreciation		Abbott House Realty, LLC	100.00%	13,260	13,260	7
8	V	32 Interest Income	442	Abbott House Realty, LLC	100.00%		(442)	8
9	V	21 State Replacement Tax		Abbott House Realty, LLC	100.00%	5,028	5,028	9
10	V	21 Bank Charges		Abbott House Realty, LLC	100.00%	63	63	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 484,104			\$ 86,988	\$ * (397,116)	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>5 UTILITIES</u>	\$	<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	\$ 341	\$	341	15
16	V	<u>19 PROFESSIONAL FEES</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	525		525	16
17	V	<u>21 CLERICAL AND GENERAL</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	1,221		1,221	17
18	V	<u>26 INSURANCE</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	26		26	18
19	V	<u>30 DEPRECIATION</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	19		19	19
20	V	<u>34 RENT</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	13,678		13,678	20
21	V	<u>35 EQUIPMENT RENT</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	974		974	21
22	V								22
23	V								23
24	V								24
25	V	<u>17 ADM. COMP.- IVY FISHMAN</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	10,000		10,000	25
26	V	<u>17 ADM. COMP.- A. ROSENBAUM</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%				26
27	V	<u>17 SALARY - A. ROSENBAUM</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%				27
28	V	<u>21 CLERICAL COMP</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	49,880		49,880	28
29	V	<u>27 EMP. BEN.-DIRECT ALLOC.</u>		<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%	18,149		18,149	29
30	V								30
31	V								31
32	V	<u>17 HOME OFFICE</u>	36,000	<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%			(36,000)	32
33	V	<u>21 HOME OFFICE CLERICAL</u>	54,016	<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%			(54,016)	33
34	V	<u>22 HOME OFFICE BENEFITS</u>	19,002	<u>A.H.B. D/B/A ABH MANAGEMENT</u>	100.00%			(19,002)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 109,019			\$ 94,813	\$ *	(14,206)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 100,000	\$ 100,000
16	V	19 PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%		
17	V	27 EMPLOYEE BENEFITS		KARLA BISHOP, INC.	100.00%	18,437	18,437
18	V						
19	V						
20	V						
21	V	17 MANAGEMENT FEES	181,500	KARLA BISHOP, INC.	100.00%		(181,500)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 181,500			\$ 118,437	\$ * (63,063)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 50,000	\$ 50,000
16	V	19 PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	94	94
17	V	27 EMPLOYEE BENEFITS		HEALTH RESOURCE, INC.	100.00%	8,557	8,557
18	V						
19	V	17 MANAGEMENT FEES	208,124	HEALTH RESOURCE, INC.	100.00%		(208,124)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 208,124			\$ 58,651	\$ * (149,473)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

Facility Name & ID Number

Abbott House

0023739

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	ALAN ROSENBAUM REVOCABLE TRUST	1.002%	BAYSIDE TERRACE LLC	WAUKEGAN	ABBOTT HOUSE REALTY, LLC		BUILDING CO.	1
2	CHARLES D. ZIS REVOCABLE TRUST	1.011%	HILLCREST RETIREMENT VILLAGE, LTD.	ROUND LAKE BEACH	KARLA BISHOP, INC.	LAKE BLUFF	MANAGEMENT CO.	2
3	CHRISTINE G. GARBER REV. TRUST	3.032%			A.H.B. D/B/A ABH MANAGEMEN	HIGHLAND PARK	HOME OFFICE	3
4	CHRISTINE GARBER	1.011%			HEALTH RESOURCE, INC.	HIGHLAND PARK	MANAGEMENT CO.	4
5	CORINNE AHRENS	0.500%						5
6	EARL L ROSENBAUM DECLARATION TRUST	40.533%						6
7	EDWARD AND NANCY OSMOLAK	4.896%						7
8	GEORGE M. ZAK	1.079%						8
9	H A KEATS & G A KEATS REALTY	1.079%						9
10	HEALTH RESOURCE INC.	1.000%						10
11	ILA ROSENBAUM	0.405%						11
12	IRA & MARJORIE MARGOLIS	2.021%						12
13	IRENE K. SILBERMAN REVOCABLE TRUST	3.238%						13
14	IVY ROSENBAUM REVOCABLE TRUST	1.002%						14
15	JACK R. FROST	0.505%						15
16	JAMES FROST	0.505%						16
17	JUDY ROSENBAUM	5.396%						17
18	KARLA BISHOP INC	14.124%						18
19	LAWRENCE JUTOVSKY TRUST	0.540%						19
20	LAWRENCE A SAVITT & BURT ROSENBERG	3.238%						20
21	MICHELLE SACKETT	1.079%						21
22	MITCHELL ROSENBAUM	0.405%						22
23	PAUL ROSENBAUM	0.405%						23
24	PHYLLIS J. BALMAT	1.079%						24
25	RALPH GOREN	1.079%						25
26	RALPH ROSENBAUM	0.405%						26
27	SANFORD AND BARBARA ALPER	1.000%						27
28	SANFORD AND NANCY RICHMAN	3.238%						28
29	SANDRA GOLD	1.619%						29
30	JUDITH JUTOVSKY TRUST 10/02/02	0.540%						30

SEE ACCOUNTANTS' COMPILATION REPORT

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	Moschel Family Irrevocable Trust	3.032						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

Facility Name & ID Number

Abbott House

0023739

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ivy Fishman	Administrator	Administrative	1.00%	See Attached	40	100.00%	Sal,Mgt Comp	\$ 177,087	17-1,17-7	1
2	Karla Bishop	General Partner	Administrative	14.12%	See Attached	20	50.00%	Alloc.	100,000	17-7	2
3	Earl Rosenbaum	General Partner	Administrative	40.53%	See Attached	10	25.00%	Alloc.	50,000	17-7	3
4	Mitchell Rosenbaum	Maintenance	Maintenance	0.40%	See Attached	30	100.00%	Salary	40,195	6-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 367,282		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 Abbott House

0023739

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Abbott House

0023739

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

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

Name of Related Organization A.H.B. D/B/A ABH MANAGEMENT
 Street Address 600 CENTRAL AVENUE
 City / State / Zip Code HIGHLAND PARK, IL 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	140,002	3	\$ 1,319	\$ 36,151	\$ 341	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	140,002	3	2,034	36,151	525	2
3	21	CLERICAL AND GENERAL	PATIENT DAYS	140,002	3	4,730	36,151	1,221	3
4	26	INSURANCE	PATIENT DAYS	140,002	3	100	36,151	26	4
5	30	DEPRECIATION	PATIENT DAYS	140,002	3	72	36,151	19	5
6	34	RENT	PATIENT DAYS	140,002	3	52,969	36,151	13,678	6
7	35	EQUIPMENT RENT	PATIENT DAYS	140,002	3	3,770	36,151	974	7
8									8
9									9
10									10
11	17	ADM. COMP.- IVY FISHMAN	AVG. HOURS WORKED	40	1	10,000	40	10,000	11
12	17	ADM. COMP.- A. ROSENBAUM	AVG. HOURS WORKED	40	1				12
13	17	SALARY - A. ROSENBAUM	AVG. HOURS WORKED	40	1	26,000	26,000		13
14	21	CLERICAL COMP	AVG. HOURS WORKED	40	1	49,880	49,880	40	49,880
15	27	EMP. BEN.-DIRECT ALLOC.	DIRECT		2	31,230			18,149
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 182,104	\$ 75,880	\$ 94,813	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Abbott House

0023739

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

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

Name of Related Organization KARLA BISHOP, INC.
 Street Address 271 RIVERS DRIVE
 City / State / Zip Code LAKE BLUFF, IL. 60044
 Phone Number (847)432-7262
 Fax Number (847)432-6095

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - KARLA BISHOP	AVG. HOURS WORKED 40	3	\$ 200,000	\$ 200,000	20	\$ 100,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 40	3			20		2
3	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 40	3	36,874		20	18,437	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				\$ 236,874	\$ 200,000		\$ 118,437	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Abbott House

0023739

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

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

Name of Related Organization HEALTH RESOURCE, INC.
 Street Address P.O. BOX 1275
 City / State / Zip Code HIGHLAND PARK, IL. 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED 40	3	\$ 200,000	\$ 200,000	10	\$ 50,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 40	3	375		10	94	2
3	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 40	3	34,229		10	8,557	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				\$ 234,604	\$ 200,000		\$ 58,651	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Abbott House

0023739

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Abbott House

0023739

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Abbott House

0023739

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Abbott House

0023739

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Abbott House

0023739 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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 Abbott House

0023739

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

Abbott House

0023739

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										
										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	Lake Forest Bank & Trust		X			\$	26,220			\$	1								
2	JP Morgan Chase		X								100								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	JP Morgan Chase		X								2,843								
7	Auto		X				76,364				1,866								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related					\$	102,584			\$	4,808								
B. Non-Facility Related*																			
10	Interest Income		X								(4,366)								
11	Interest Income - Bldg. Co		X								(442)								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related					\$				\$	(4,808)								
15	TOTALS (line 9+line14)					\$	102,584			\$	(0)								

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

Abbott House

0023739

Report Period Beginning:

01/01/12

Ending:

12/31/12

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										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									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.)

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Abbott House COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0023739

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>16-23-407-031</u>	<u>Long Term Care Property</u>	\$ <u>52,237.90</u>	\$ <u>52,237.90</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	\$ _____	_____	\$ _____
5.	_____	\$ _____	_____	\$ _____
6.	_____	\$ _____	_____	\$ _____
7.	_____	\$ _____	_____	\$ _____
8.	_____	\$ _____	_____	\$ _____
9.	_____	\$ _____	_____	\$ _____
10.	_____	\$ _____	_____	\$ _____
TOTALS			\$ <u><u>52,237.90</u></u>	\$ <u><u>52,237.90</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. Tax Bills

Attach a copy of the original 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.**

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/12

Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>1,977</u>		\$ <u>58,752</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	1,977		\$ 58,752	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	106	1977	1977	\$ 25,500	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1977	12,036		20			12,036	9
10	Various		1989	1,665		20			1,662	10
11	Various		1997	3,270		20	164	164	2,836	11
12	Various		1998	3,799		20	65	65	3,646	12
13	Various		2006	17,374		20	1,899	1,899	16,740	13
14	Various		2007	24,593		20	3,099	3,099	16,545	14
15	Various		2008	2,795		20	559	559	2,562	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

*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		1,434,435	13,260		25,155	11,895	495,893	67
68		2,330	19		52	33	1,821	68
69			1,160			(1,160)		69
70		\$ 1,527,796	\$ 14,439		\$ 30,993	\$ 16,554	\$ 553,740	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Abbott House

0023739

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,527,796	\$ 14,439		\$ 30,993	\$ 16,554	\$ 553,740	1
2	Nurse Call System	2009	38,120		20	1,906	1,906	6,830	2
3	Fire Alarm Sprinkler System	2009	128,630		20	12,863	12,863	48,236	3
4	Sprinkler Fees	2009	2,745		20	275	275	1,098	4
5	Boiler	2009	16,987		20	1,416	1,416	4,483	5
6	Boiler	2009	5,455		20	455	455	1,440	6
7	Fire Project	2009	9,064		20	906	906	2,795	7
8	Sprinkler System Project	2010	13,175		20	659	659	1,976	8
9	Fire Alarm Anunciator	2010	2,840		20	142	142	426	9
10	Furnished & Installed Flow Control Valve	2010	5,354		20	268	268	781	10
11	Furnish & Install Motor Starter	2010	3,819		20	191	191	398	11
12	Soffit And Siding	2011	5,910		20	591	591	690	12
13	Replace Smoke Detectors	2011	3,382		20	169	169	254	13
14	Roof Repair	2011	3,600		20	1,800	1,800	2,400	14
15	Repair Roof-Windows-Doors	2012	5,886		20	294	294	294	15
16	Install 1St Floor 2 Circuit For Front Office	2012	2,800		20	140	140	140	16
17	Sewer Repair	2012	3,641		20	182	182	182	17
18	Fire Alarm Rapir Due To Water Damage	2012	7,558		20	378	378	378	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)		\$ 1,786,762	\$ 14,439		\$ 53,627	\$ 39,188	\$ 626,540	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,786,762	\$ 14,439		\$ 53,627	\$ 39,188	\$ 626,540	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)	\$ 1,786,762	\$ 14,439		\$ 53,627	\$ 39,188	\$ 626,540	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,786,762	\$ 14,439		\$ 53,627	\$ 39,188	\$ 626,540	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)	\$ 1,786,762	\$ 14,439		\$ 53,627	\$ 39,188	\$ 626,540	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,786,762	\$ 14,439		\$ 53,627	\$ 39,188	\$ 626,540	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)	\$ 1,786,762	\$ 14,439		\$ 53,627	\$ 39,188	\$ 626,540	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Abbott House

0023739

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1977	797,436	13,260			(13,260)		3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	1978	5,113		20			5,113	9
10	Various	1979	9,225		20			9,225	10
11	Various	1980	12,137		20			12,137	11
12	Various	1981	391		20			391	12
13	Various	1982	442		20			442	13
14	Various	1983	1,570		20			1,570	14
15	Various	1984	6,914		20			6,914	15
16	Various	1985	16,470		20			16,470	16
17	Various	1986	41,754		20			41,754	17
18	Various	1989	11,668		20			11,668	18
19	Various	1990	1,458		20			1,458	19
20	Various	1991	5,843		20			5,843	20
21	Various	1992	20,907		20			20,907	21
22	Various	1993	58,704		20	2,935	2,935	58,700	22
23	Various	1994	21,039		20	1,052	1,052	19,988	23
24	Various	1995	26,190		20	1,309	1,309	23,562	24
25	Various	1996	59,095		20	2,955	2,955	50,235	25
26	Various	1997	22,563		20	1,128	1,128	18,048	26
27	Various	1998	76,806		20	3,840	3,840	57,600	27
28	Various	1999	18,653		20	933	933	13,062	28
29	Various	2000	28,615		20	1,431	1,431	18,603	29
30	Various	2001	117,689		20	5,884	5,884	70,608	30
31	Various	2002	10,682		20	534	534	5,874	31
32	Various	2003	7,176		20	359	359	3,590	32
33	Various	2004	2,902		20	145	145	1,305	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Various	2005	45,570		20	2,279	2,279	18,228	2
3	Fire Alarm System	2006	3,966		20	198	198	1,388	3
4	Replace Boiler Piping	2006	3,457		20	173	173	1,210	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 1,434,435	\$ 13,260		\$ 25,155	\$ 11,895	\$ 495,893	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ABH Management	2002	2,199	19	20	52	33	1,690	9
10	Allocated from ABH Management	2003	131		20			131	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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 2,330	\$ 19		\$ 52	\$ 33	\$ 1,821	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Abbott House

0023739

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	\$ 117,354	\$	\$ 7,027	\$ 7,027	10	\$ 99,768	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	406,907		138	138	10	406,907	73
74								74
75	TOTALS	\$ 524,261	\$	\$ 7,165	\$ 7,165		\$ 506,675	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		LEXUS LS460	2011	\$ 30,000	\$	\$ 7,650	\$ 7,650	5	\$ 12,150	76
77										77
78										78
79										79
80	TOTALS			\$ 30,000	\$	\$ 7,650	\$ 7,650		\$ 12,150	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)	\$ 2,399,775	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,439	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,442	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 54,003	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,145,364	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	2012 BUICK ENCLAVE - 2012	\$ 53,342	\$ 11,340	\$ 22,680	86
87	Lexus LS460 - 2011	56,700	8,001	8,001	87
88					88
89					89
90					90
91	TOTALS	\$ 110,042	\$ 19,341	\$ 30,681	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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	Storage				3,520			5
6	Alloc ABH Management				13,678			6
7	TOTAL				\$ 17,198			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: _____ *

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: \$ 4,834 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

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 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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

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

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Abbott House# 0023739Report Period Beginning: 01/01/12Ending: 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	\$ 184,549	\$ 616,660	1
2	Cash-Patient Deposits	27,989	27,989	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	514,147	1,151,383	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,199	57,199	6
7	Other Prepaid Expenses	220,710	220,710	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	61,793	63,427	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,066,387	\$ 2,137,368	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		58,752	13
14	Buildings, at Historical Cost		1,391,921	14
15	Leasehold Improvements, at Historical Cost	271,849	271,849	15
16	Equipment, at Historical Cost	721,966	721,966	16
17	Accumulated Depreciation (book methods)	(699,959)	(1,792,027)	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): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 293,856	\$ 652,461	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,360,243	\$ 2,789,829	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 251,591	\$ 251,591	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,819	26,819	28
29	Short-Term Notes Payable	69,727	69,727	29
30	Accrued Salaries Payable	86,101	86,101	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,522	7,522	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,000	54,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	659,736	659,736	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,155,496	\$ 1,155,496	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	32,857	32,857	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 32,857	\$ 32,857	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,188,353	\$ 1,188,353	46
47	TOTAL EQUITY(page 18, line 24)	\$ 171,890	\$ 1,601,476	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,360,243	\$ 2,789,829	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 258,734	1
2	Restatements (describe):		2
3	Closing Prior Years P&L	(5,891)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 252,843	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(80,953)	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)	\$ (80,953)	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)	\$ 171,890	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Abbott House**# **0023739**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**

1		Amount	
I. Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,721,385	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,721,385	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	33,842	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)	\$ 33,842	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	58,703	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58,703	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	11,376	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,376	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,825,306	30

2		Amount	
II. Expenses			
A. Operating Expenses			
31	General Services	1,091,655	31
32	Health Care	1,207,074	32
33	General Administration	1,616,586	33
B. Capital Expense			
34	Ownership	508,369	34
C. Ancillary Expense			
35	Special Cost Centers	37,082	35
36	Provider Participation Fee	445,493	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,906,259	40
41	Income before Income Taxes (line 30 minus line 40)**	(80,953)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (80,953)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,184,108	44
45	Private Pay - Net Inpatient Revenue	370,077	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)	167,200	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,721,385	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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

Facility Name & ID Number **Abbott House**

0023739

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,896	2,080	\$ 79,245	\$ 38.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,370	9,990	298,937	29.92	3
4	Licensed Practical Nurses	5,799	6,220	140,304	22.56	4
5	CNAs & Orderlies	23,043	24,958	293,135	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,270	6,920	95,285	13.77	10
11	Social Service Workers	9,732	10,690	201,154	18.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,142	22,388	288,698	12.90	15
16	Dishwashers					16
17	Maintenance Workers	6,762	7,624	113,456	14.88	17
18	Housekeepers	10,144	11,435	170,183	14.88	18
19	Laundry	3,583	4,320	53,018	12.27	19
20	Administrator	2,080	2,080	167,087	80.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,310	12,372	155,548	12.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	110,131	121,077	\$ 2,056,050 *	\$ 16.98	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 7,404	01-03	35
36	Medical Director	Monthly	3,400	09-03	36
37	Medical Records Consultant	Monthly	6,400	10-03	37
38	Nurse Consultant	Monthly	360	10-03	38
39	Pharmacist Consultant	Monthly	6,124	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	4,125	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	8,309	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,122		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Ivy Fishman	Administrator	1%	\$ 167,087	Workers' Compensation Insurance	\$ 28,361	IDPH License Fee	\$		
				Unemployment Compensation Insurance	32,430	Advertising: Employee Recruitment			
				FICA Taxes	150,520	Health Care Worker Background Check			
				Employee Health Insurance	125,110	(Indicate # of checks performed <u>93</u>)	937		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	8,092		
				Other Employee Benefits	6,558	Licenses & Fees	4,297		
				Christmas Expense	11,118				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 167,087	TOTAL (agree to Schedule V, line 22, col.8)			\$ 354,097	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Karla Bishop - Administrative			\$ 181,500				Out-of-State Travel	\$	
Health Resources, Inc - Management/Bookkeeping			208,124						
ABH Management - Management Fees			36,000				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 425,624				Seminar Expense	6,152	
C. Professional Services				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type		Amount				TOTAL		
Frost, Ruttenberg & Rothblatt	Accounting		\$ 78,357				\$ 6,152		
Alexander Popa	Computer Consultant		15,830						
Paychex	Payroll Processing		4,971						
Jane Osa	Pension Admin. Fees		2,210						
Much Shelist	Legal		9,888						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 111,256						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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 Abbott House# 0023739

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? Yes
If YES, give association name and amount. Alliance for Living \$196
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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. \$ 981 Line 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 445,493
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? N/A
- (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? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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? N/A
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.

SEE ACCOUNTANTS' COMPILATION REPORT