

Facility Name & ID Number Park House Nrsng & Rehab Ctr

0050740 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		267	3,261	3,528	8
9	SNF/PED					9
10	ICF	29,961			29,961	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,961	267	3,261	33,489	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.56%

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

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 12/16/09

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/16/09 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 14 and days of care provided 3,250

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsrg & Rehab Ctr # 0050740 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	212,304	20,458	7,511	240,273		240,273	(2,057)	238,216		1
2	Food Purchase		163,527		163,527		163,527	386	163,913		2
3	Housekeeping	178,503	18,895		197,398		197,398	386	197,784		3
4	Laundry	44,205	12,076		56,281		56,281		56,281		4
5	Heat and Other Utilities			111,217	111,217		111,217	510	111,727		5
6	Maintenance	67,214		132,994	200,208		200,208	12,098	212,306		6
7	Other (specify):* See Supplemental	44,568			44,568		44,568	651	45,219		7
8	TOTAL General Services	546,794	214,956	251,722	1,013,472		1,013,472	11,974	1,025,446		8
	B. Health Care and Programs										
9	Medical Director			29,900	29,900		29,900		29,900		9
10	Nursing and Medical Records	1,216,341	28,753	14,653	1,259,747		1,259,747	(77)	1,259,670		10
10a	Therapy	95,278			95,278		95,278		95,278		10a
11	Activities	68,929	16,318	1,680	86,927		86,927		86,927		11
12	Social Services	296,458	24,074	2,726	323,258		323,258		323,258		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,677,006	69,145	48,959	1,795,110		1,795,110	(77)	1,795,033		16
	C. General Administration										
17	Administrative	192,805			192,805		192,805	16,648	209,453		17
18	Directors Fees										18
19	Professional Services			241,174	241,174	(6,395)	234,779	(125,205)	109,574		19
20	Dues, Fees, Subscriptions & Promotions			29,367	29,367		29,367	(10,431)	18,936		20
21	Clerical & General Office Expenses	101,223	18,405	429,667	549,295		549,295	(318,455)	230,840		21
22	Employee Benefits & Payroll Taxes			467,542	467,542		467,542	(4,740)	462,802		22
23	Inservice Training & Education			1,078	1,078		1,078		1,078		23
24	Travel and Seminar			1,618	1,618		1,618	292	1,910		24
25	Other Admin. Staff Transportation			10,609	10,609		10,609	775	11,384		25
26	Insurance-Prop.Liab.Malpractice			125,390	125,390		125,390	1,044	126,434		26
27	Other (specify):* See Supplemental							20,771	20,771		27
28	TOTAL General Administration	294,028	18,405	1,306,445	1,618,878	(6,395)	1,612,483	(419,301)	1,193,182		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,517,828	302,506	1,607,126	4,427,460	(6,395)	4,421,065	(407,404)	4,013,661		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 Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	44,568		
Alloc. Extended Care Consulting, LLC			651
Total	44,568	-	651
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Alloc. Extended Care Consulting, LLC			20,771
Total	-	-	20,771

**Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 3 Supplemental Schedule - Reclass

Description	Cost Center	Increase	Decrease
Real Estate Taxes	33	6,395	
Professional Fees	19		6,395

Facility Name & ID Number

Park House Nrsg & Rehab Ctr

#0050740

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			7,148	7,148		7,148	4,627	11,775			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,342	1,342		1,342	(1,342)				32
33	Real Estate Taxes			153,606	153,606	6,395	160,001	(9,495)	150,506			33
34	Rent-Facility & Grounds			121,162	121,162		121,162	(121,000)	162			34
35	Rent-Equipment & Vehicles			17,455	17,455		17,455	733	18,188			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			300,713	300,713	6,395	307,108	(126,477)	180,631			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		197,413	380,208	577,621		577,621	(3,514)	574,107			39
40	Barber and Beauty Shops			1,952	1,952		1,952		1,952			40
41	Coffee and Gift Shops			240,620	240,620		240,620		240,620			41
42	Provider Participation Fee											42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers		197,413	622,780	820,193		820,193	(3,514)	816,679			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,517,828	499,919	2,530,619	5,548,366		5,548,366	(537,395)	5,010,971			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	(320)	21		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	(2,226)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,238)	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	(7,396)	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	(397,667)	21		24
25	Fund Raising, Advertising and Promotional	(12,711)	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 Supplemental Schedule	(161,153)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (583,711)		\$	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)	46,316		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 46,316		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (537,395)		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	52

SEE ACCOUNTANTS' COMPILATION REPORT

Park House Nrsg & Rehab Ctr

ID# 0050740

Report Period Beginning: 01/01/13

Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (10,132)	21	1
2	Cook County Sales Tax	(68)	21	2
3	Theft	(135)	21	3
4	Collection Expense	(2,244)	21	4
5	Non-Allowable Interest	(121,401)	32	5
6	Non-Allowable Depreciation (Expensed FA)	(66)	30	6
7	Expensed Fixed Assets < \$2,500	2,419	06	7
8	Non-Allowable Legal Expense	(17,683)	19	8
9	Real Estate Tax Refund Adjustment	(11,493)	33	9
10				10
11				11
12				12
13				13
14	2320 South Lawndale, LLC			14
15	Amortization	(350)	31	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(161,153)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park House Nrsng & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	(2,238)	0	219	0	(38)	0	0	0	0	0	0	(2,057)	1
2	Food Purchase	0	0	386	0	0	0	0	0	0	0	0	386	2
3	Housekeeping	0	0	386	0	0	0	0	0	0	0	0	386	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	510	0	0	0	0	0	0	0	0	510	5
6	Maintenance	2,419	0	3,330	6,349	0	0	0	0	0	0	0	12,098	6
7	Other (specify):*	0	0	0	651	0	0	0	0	0	0	0	651	7
8	TOTAL General Services	181	0	4,831	7,000	(38)	0	0	0	0	0	0	11,974	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(77)	0	0	0	0	0	0	(77)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	(77)	0	0	0	0	0	0	(77)	16
	C. General Administration													
17	Administrative	0	0	2,553	14,095	0	0	0	0	0	0	0	16,648	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,683)	0	(107,522)	0	0	0	0	0	0	0	0	(125,205)	19
20	Fees, Subscriptions & Promotions	(12,711)	0	2,280	0	0	0	0	0	0	0	0	(10,431)	20
21	Clerical & General Office Expenses	(417,962)	0	10,777	88,730	0	0	0	0	0	0	0	(318,455)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(4,740)	0	0	0	0	0	0	0	(4,740)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	292	0	0	0	0	0	0	0	0	292	24
25	Other Admin. Staff Transportation	0	0	775	0	0	0	0	0	0	0	0	775	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,044	0	0	0	0	0	0	0	0	1,044	26
27	Other (specify):*	0	0	0	20,771	0	0	0	0	0	0	0	20,771	27
28	TOTAL General Administration	(448,356)	0	(89,801)	118,856	0	0	0	0	0	0	0	(419,301)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(448,175)	0	(84,970)	125,856	(115)	0	0	0	0	0	0	(407,404)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park House Nrsg & Rehab Ctr# 0050740

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(66)	0	4,693	0	0	0	0	0	0	0	0	4,627	30
31	Amortization of Pre-Op. & Org.	(350)	350	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(123,627)	121,000	1,285	0	0	0	0	0	0	0	0	(1,342)	32
33	Real Estate Taxes	(11,493)	0	1,998	0	0	0	0	0	0	0	0	(9,495)	33
34	Rent-Facility & Grounds	0	(121,000)	0	0	0	0	0	0	0	0	0	(121,000)	34
35	Rent-Equipment & Vehicles	0	0	733	0	0	0	0	0	0	0	0	733	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(135,536)	350	8,709	0	0	0	0	0	0	0	0	(126,477)	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	(663)	(2,851)	0	0	0	0	0	(3,514)	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	(663)	(2,851)	0	0	0	0	0	(3,514)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(583,711)	350	(76,261)	125,856	(778)	(2,851)	0	0	0	0	0	(537,395)	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 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. 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 Rent	\$ 121,000	2320 South Lawndale, LLC	100.00%	\$	\$ (121,000)	1
2	V	31 Amortization		2320 South Lawndale, LLC	100.00%	350	350	2
3	V	32 Interest		2320 South Lawndale, LLC	100.00%	121,000	121,000	3
4	V	33 Real Estate Taxes	160,741	2320 South Lawndale, LLC	100.00%	160,741		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		\$ 281,741			\$ 282,091	\$ * 350	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 219	\$ 219	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	386	386	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	386	386	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	510	510	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,330	3,330	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,553	2,553	20
21	V	19 Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	6,478	(107,522)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,280	2,280	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	10,777	10,777	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	292	292	24
25	V	25 Other Staff Admin. Transportation		Extended Care Consulting, LLC	100.00%	775	775	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,044	1,044	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,693	4,693	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	1,285	1,285	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,998	1,998	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	733	733	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			\$ 37,739	\$ * (76,261)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	06 Maintenance	\$	Extended Care Consulting, LLC	100.00%	\$ 6,349	\$ 6,349	15
16	V	06 Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07 Emp. Ben. - Gen. Services		Extended Care Consulting, LLC	100.00%	651	651	17
18	V	07 Emp. Ben. - Gen. Services		Extended Care Consulting, LLC	100.00%			18
19	V	17 Administrative		Extended Care Consulting, LLC	100.00%	14,095	14,095	19
20	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	88,730	88,730	20
21	V	21 Office and Clerical	15,799	Extended Care Consulting, LLC	100.00%	15,799		21
22	V	27 Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC	100.00%	19,205	19,205	22
23	V	27 Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC	100.00%	1,566	1,566	23
24	V	22 Employee Benefits	4,740	Extended Care Consulting, LLC	100.00%		(4,740)	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		\$ 20,539			\$ 146,395	\$ * 125,856	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1 Dietary	\$ 136	Care Centers Health Systems, Inc.	100.00%	\$ 98	\$	(38)	15
16	V	10 Nursing	275	Care Centers Health Systems, Inc.	100.00%	198		(77)	16
17	V	39 Ancillary	2,369	Care Centers Health Systems, Inc.	100.00%	1,706		(663)	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		\$ 2,780			\$ 2,002	\$ *	(778)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	39 Ancillary	\$ 147,328	Tricare Rehab	100.00%	\$ 144,477	\$	(2,851)	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		\$ 147,328			\$ 144,477	\$ *	(2,851)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	39 Ancillary	\$	Reliable Medical of the Midwest, LLC	100.00%	\$	\$	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		\$			\$	0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	22 Employee Benefits	\$ 26,196	CCS VEBA	100.00%	\$ 26,196	\$	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		\$ 26,196			\$ 26,196	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr # 0050740 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Adam Vales	Relative	Clerical	0.00	See Attached	0.24	0.60%	Alloc. Salary	\$ 426	22 - 07	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	\$ 426		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 Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Park House Nrsng & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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	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	01	Dietary	Patient Days	1,101,784	30	\$ 7,195	\$ 33,489	\$ 219	1
2	02	Food	Patient Days	1,101,784	30	12,684	33,489	386	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707	33,489	386	3
4	05	Utilities	Patient Days	1,101,784	30	16,778	33,489	510	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559	33,489	3,330	5
6	17	Administrative	Patient Days	1,101,784	30	84,000	33,489	2,553	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139	33,489	6,478	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016	33,489	2,280	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548	33,489	10,777	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615	33,489	292	10
11	25	Other Staff Admin. Transport.	Patient Days	1,101,784	30	25,510	33,489	775	11
12	26	Insurance	Patient Days	1,101,784	30	34,345	33,489	1,044	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393	33,489	4,693	13
14	32	Interest	Patient Days	1,101,784	30	42,261	33,489	1,285	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749	33,489	1,998	15
16	35	Rent - Equipment and Auto	Patient Days	1,101,784	30	24,117	33,489	733	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,241,616	\$	\$ 37,739	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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	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	06	Maintenance	Patient Days	1,101,784	30	\$ 208,870	\$ 208,870	33,489	\$ 6,349	1
2	06	Maintenance	Direct	1	1			1		2
3	07	Emp. Ben. - Gen. Services	Patient Days	1,101,784	30	21,409	21,409	33,489	651	3
4	07	Emp. Ben. - Gen. Services	Direct	1	1			1		4
5	17	Administrative	Patient Days	1,101,784	30	463,710	463,710	33,489	14,095	5
6	21	Office and Clerical	Patient Days	1,101,784	30	2,919,199	2,919,199	33,489	88,730	6
7	21	Office and Clerical	Direct	1	1	15,799	15,799	1	15,799	7
8	27	Emp. Ben. - Gen. Admin.	Patient Days	1,101,784	30	631,850	631,850	33,489	19,205	8
9	27	Emp. Ben. - Gen. Admin.	Direct	1	1	1,566		1	1,566	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					\$ 4,262,403	\$ 4,260,837		\$ 146,395	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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	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	Dietary	Profit Margin %	122,604	23	\$ 88,277	\$ 136	\$ 98	1
2	10	Nursing	Profit Margin %	5,445	23	3,920	275	198	2
3	39	Ancillary	Profit Margin %	139,357	23	100,339	2,369	1,706	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					\$ 192,536	\$	\$ 2,002	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Tricare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, Illinois 60162
 Phone Number (708) 449 - 9400
 Fax Number (708) 449 - 9700

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	39	Ancillary	Profit Margin %	10,291,244	19	\$ 10,092,129	\$ 147,328	\$ 144,477	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					\$ 10,092,129	\$	\$ 144,477	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue, Suite 246
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (847) 566 - 0800
 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	39	Ancillary	Profit Margin %	13	\$ 192,763	\$		\$
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25	TOTALS				\$ 192,763	\$		\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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	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	22	Employee Benefits	1	1	\$ 26,196	\$	1	\$ 26,196	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				\$ 26,196	\$		\$ 26,196	25

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park House Nrsng & Rehab Ctr COUNTY Morgan
 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-26-105-075-0000</u>	<u>Long Term Care Facility</u>	\$ <u>40,509.45</u>	\$ <u>40,509.45</u>
2. <u>16-26-105-079-0000</u>	<u>Long Term Care Facility</u>	\$ <u>50,130.06</u>	\$ <u>50,130.06</u>
3. <u>16-26-105-080-0000</u>	<u>Long Term Care Facility</u>	\$ <u>50,222.67</u>	\$ <u>50,222.67</u>
4. <u>Allocation</u>	<u>Long Term Care Facility</u>	\$ <u>133,178.74</u>	\$ <u>1,636.29</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>274,040.92</u></u>	\$ <u><u>142,498.47</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? 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 10 Supplemental Schedule

Vendor	Description	Amount
Appeal Costs		
Finkel, Martwick & Colson, P.C.	2010 - Tax Refund Legal Fees	4,221
Finkel, Martwick & Colson, P.C.	2012 - Tax Reduction Legal Fees	2,174
Total - Line 5 Total		6,395
Refunds		
Total		-
Refund Adjustment		
Appeal Costs		6,395
Real Estate Tax Refund	16,591	
Appeal Costs	6,395	
Remainder	10,196	
1/2 of Remainder		5,098
Total - Line 6 Total		11,493

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

N/A

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	Facility			\$ 40,650	1
2	Alloc. Extended Care			9,701	2
3	TOTALS			\$ 50,351	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		
	Bed*s	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	106		1989		\$ 1,209,350	\$		\$	\$	\$ 1,173,537	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	Various		2009		154,704						29
30	Water Heater and Roof Exhaust		2011		8,534	427		427		1,067	30
31	Six Delay Egress Doors		2011		4,630	926		926		2,084	31
32	Electrical Circuits with 2 Outlets		2013		3,500	117		117		117	32
33	Fire Dampers		2013		3,900	95		95		95	33
34	Hollow Metal Doors and Steel Frame		2013		5,228	133		133		133	34
35	Floor Drain - Sprinkler Room		2013		6,650						35
36	Conduit, Relay, and Annunciator Panel		2013		2,983						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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,045,790	\$ 1,698		\$ 1,698	\$	\$ 1,177,033	70

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	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		\$ 2,045,790	\$ 1,698		\$ 1,698	\$	\$ 1,177,033	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5									5
6	Allocations - Extended Care Consulting	2007	140	7		7		49	6
7	Allocations - Extended Care Consulting	2009	84	4		4		21	7
8	Allocations - Extended Care Consulting	2010	820	41		41		164	8
9	Allocations - Extended Care Consulting	2011	295	15		15		44	9
10	Allocations - Extended Care Consulting	2012	97	5		5		10	10
11									11
12									12
13	Allocations - Extended Care Consulting / 2201 Main LLC	2002	13,368	343		343		3,871	13
14	Allocations - Extended Care Consulting / 2201 Main LLC	2002	11,043	1,009		1,009		10,102	14
15	Allocations - Extended Care Consulting / 2201 Main LLC	2003	13,014	1,189		1,189		11,905	15
16	Allocations - Extended Care Consulting / 2201 Main LLC	2005	647	69		69		508	16
17	Allocations - Extended Care Consulting / 2201 Main LLC	2009	117	6		6		29	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)		\$ 2,085,415	\$ 4,386		\$ 4,386	\$	\$ 1,203,736	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 19,151	\$ 3,830	\$ 3,830	\$	5 - 7	\$ 9,330	71
72	Current Year Purchases	24,583	1,554	1,554		5 - 7	1,554	72
73	Fully Depreciated Assets							73
74	See Supplemental	326,158	2,005	2,005			323,991	74
75	TOTALS	\$ 369,892	\$ 7,389	\$ 7,389	\$		\$ 334,875	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			4,711					4,711	77
78										78
79										79
80	TOTALS			\$ 4,711	\$	\$	\$		\$ 4,711	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)	\$ 2,510,369	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,775	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,775	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)	\$ 1,543,322	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

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, LLC			
Prior	89,295	314	87,669
Current	601	60	60
Total	89,896	374	87,729
Related Party 3 - Extended Care Consulting, LLC / 2201 Main LLC			
Prior	3,702	43	3,702
Current			
Total	3,702	43	3,702
Related Party 4 - Vent Lease - Matrix Software			
Prior	32,560	1,588	32,560
Current			
Total	32,560	1,588	32,560
Total	326,158	2,005	323,991

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See							5
6	Supplement				162			6
7	TOTAL				\$ 162			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: \$ 13,899 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	Infinity	\$	\$ 4,289	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,289	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.	<u>/2014</u>	\$ _____
13.	<u>/2015</u>	\$ _____
14.	<u>/2016</u>	\$ _____

* 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 Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Off-Site Rental	162
Total	<u>162</u>

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Amount
Care Consultants of Illinois	68
Chicago Office Tech	1,033
Hughes Enterprise	8,220
Wells Fargo Financial	3,846
Alloc. - Extended Care Consulting	733
Total	<u>13,899</u>

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost				
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	179,959	\$		\$	179,959	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				15,999				15,999	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				176,726				176,726	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 prescripts					158,499			158,499	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						38,914			38,914	12
13	Other (specify): See Supplemental	39 - 03					7,524				7,524	13
14	TOTAL			\$		\$	380,208	\$	197,413	\$	577,621	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 Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 16 Supplemental Schedule

Description	Supplies	Other
Oxygen	12,757	
Medical Supplies	7,857	
Therapy and Rehab Supplies	4,605	
Wheelchairs and Walkers	1,078	
Food Pump and Supplies	2,714	
Low Pressure Mattresses	5,540	
Ambulance		
Laboratory		3,703
Radiology		2,156
Ventilation Therapy		
Other	4,363	1,665
Total	38,914	7,524

Facility Name & ID Number Park House Nrsg & Rehab Ctr# 0050740Report Period Beginning: 01/01/13Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 3,972	1
2	Cash-Patient Deposits	12,810	12,810	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>571,635</u>)	1,259,409	1,259,409	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,259	52,259	6
7	Other Prepaid Expenses	158,841	158,841	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>		698,093	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,483,319	\$ 2,185,384	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		40,650	13
14	Buildings, at Historical Cost		1,020,720	14
15	Leasehold Improvements, at Historical Cost	37,844	190,661	15
16	Equipment, at Historical Cost	43,734	243,734	16
17	Accumulated Depreciation (book methods)	(14,445)	(1,387,982)	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 Supplemental Schedule</u>	8,000	92,008	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 75,133	\$ 199,791	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,558,452	\$ 2,385,175	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 837,956	\$ 837,956	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,662	12,662	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,340	116,340	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,025	5,025	31
32	Accrued Real Estate Taxes(Sch.IX-B)		147,905	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	422,926		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,394,909	\$ 1,119,888	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,200,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,200,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,394,909	\$ 4,319,888	46
47	TOTAL EQUITY(page 18, line 24)	\$ 163,543	\$ (1,934,713)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,558,452	\$ 2,385,175	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

**Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Due from Related Parties		698,093
Total	-	698,093
Line 23 - Other Long Term Assets		
State Replacement Tax Benefit	8,000	8,000
Escrows		63,365
Financing Costs (Net of Amortization)		20,643
Total	8,000	92,008
Line 36 - Other Current Liabilities		
Due to Related Parties	422,926	
Total	422,926	-
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 121,136	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 121,136	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	\$ 42,407	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)	\$ 42,407	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)	\$ 163,543	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,490,969	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,490,969	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,044	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 70,044	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***	2,226	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,226	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	27,534	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,534	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,590,773	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,013,472	31
32	Health Care	1,795,110	32
33	General Administration	1,618,878	33
B. Capital Expense			
34	Ownership	300,713	34
C. Ancillary Expense			
35	Special Cost Centers	820,193	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,548,366	40
41	Income before Income Taxes (line 30 minus line 40)**	42,407	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 42,407	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,833,719	44
45	Private Pay - Net Inpatient Revenue	33,926	45
46	Medicare - Net Inpatient Revenue	1,613,582	46
47	Other-(specify) Hospice - Net Inpatient Revenue	5,892	47
48	Other-(specify) Insurance - Net Inpatient Revenue	3,850	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,490,969	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

Facility Name & ID Number Park House Nrs & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,588	1,679	\$ 70,889	\$ 42.22	1
2	Assistant Director of Nursing	1,807	2,384	77,167	32.37	2
3	Registered Nurses	8,276	9,747	274,263	28.14	3
4	Licensed Practical Nurses	11,499	12,254	316,316	25.81	4
5	CNAs & Orderlies	38,075	42,744	448,347	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,974	4,810	95,278	19.81	8
9	Activity Director	1,810	1,990	26,605	13.37	9
10	Activity Assistants	4,003	4,449	42,324	9.51	10
11	Social Service Workers	13,865	15,456	296,458	19.18	11
12	Dietician					12
13	Food Service Supervisor	1,868	2,085	45,859	21.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,819	4,404	48,374	10.98	15
16	Dishwashers	10,046	11,374	118,072	10.38	16
17	Maintenance Workers	3,349	3,898	67,214	17.24	17
18	Housekeepers	15,570	17,065	178,503	10.46	18
19	Laundry	3,539	4,160	44,205	10.63	19
20	Administrator	1,849	2,112	99,989	47.34	20
21	Assistant Administrator	1,803	1,931	59,933	31.04	21
22	Other Administrative	364	368	32,883	89.36	22
23	Office Manager					23
24	Clerical	3,824	4,143	101,223	24.43	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	1,908	2,148	29,358	13.67	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	4,763	5,036	44,568	8.85	33
34	TOTAL (lines 1 - 33)	137,599	154,237	\$ 2,517,828 *	\$ 16.32	34

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	\$ 7,511	01 - 03	35
36	Medical Director	29,900	09 - 03	36
37	Medical Records Consultant	5,301	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	9,252	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	100	10 - 03	42
43	Speech Therapy Consultant			43
44	Activity Consultant	1,680	11 - 03	44
45	Social Service Consultant	2,726	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 56,470		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

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

** See instructions.

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		
Melissa A. Lindsay	Administrator	0	\$ 54,452	Workers' Compensation Insurance	\$ 94,655	IDPH License Fee	\$ 1,990		
Elimelech S. Ray	Administrator	0	45,537	Unemployment Compensation Insurance	69,442	Advertising: Employee Recruitment	2,950		
Lorena Robledo-Sommerfield	Asst. Admin.	0	59,933	FICA Taxes	191,832	Health Care Worker Background Check	8,620		
Sherwin Ray	Administration	0	32,883	Employee Health Insurance	89,088	(Indicate # of checks performed)			
				Employee Meals		<u>Patient Background Checks</u>			
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues and Subscriptions</u>	299		
				Employee Physicals		<u>Licenses</u>	2,797		
				Holiday Expense	1,286	<u>Advertising and Promotion</u>	12,711		
				Employee Pension	13,590	<u>Alloc. Extended Care Consulting, LLC</u>	2,280		
				Other Benefits	2,909				
						Less: Public Relations Expense	()		
						Non-allowable advertising	(12,711)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 192,805	TOTAL (agree to Schedule V, line 22, col.8)		\$ 462,802	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,936
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description	Line #	Amount	Description	Amount	
							Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,618	
							<u>Alloc. Extended Care Consulting, LLC</u>	292	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL		\$ 1,910
C. Professional Services									
Vendor/Payee	Type	Amount							
Extended Care Consulting, LLC	Home Office	\$ 114,000							
Personnel Planners, Inc.	Unemployment Consultant	2,121							
Plante & Moran, PLLC	Accounting	18,350							
Krupnick, Bokor, & Kagda	Accounting	1,795							
Singer Networks	Computer Maintenance	1,294							
Care Consultants of Illinois	Computer Maintenance	12,850							
ProPay Payroll Services	Data Processing	16,260							
Medifax	Data Processing	764							
E-Health Data Solutions	Data Processing	4,235							
American Data	Data Processing	4,221							
Nebo Systems	Data Processing	72							
See Supplemental Schedule		65,212							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 241,174						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
MDI Achieve	Data Processing	14,572
Ability Network	Data Processing	161
National Datacare Corporation	Data Processing	1,332
Omnicare of Northern Illinois	Data Processing	1,352
Comcast Cable	Data Processing	1,428
Burke, Warren, MacKay & Serritella, P.C.	Legal	4,297
Jackson Lewis, LLP	Legal	1,248
Williams Montgomery & John, Ltd.	Legal	6,505
Hall, Prangle & Schoonveld, LLC	Legal	5,696
Robbins, Salomon & Patt, Ltd.	Legal	613
Ashman & Stein	Legal	3,702
Chuhak & Tecson, P.C.	Legal	1,040
Schueler, Dallavo & Casieri	Legal	280
Meyer Magence	Legal	894
Simandl Law Group, S.C.	Legal	1,103
Finkel, Martwick & Colson, P.C.	Other	6,395
HFG	Other	5,891
Care Consultants of Illinois	Other	45
Pharmacy Price Management	Other	375
Prospect Resources, LLC	Other	1,500
Legat Architect	Other	6,739
Extended Care Consulting, LLC	Other	1,564
Other	Other	(1,517)
Total		65,212

**Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/13 - 12/31/13**

Page 21 Supplemental Schedule - Legal Details

Vendor	Invoice Date	Amount	Allowable
Schueler, Dallavo & Casieri	01/11/13	280	
Burke, Warren, MacKay & Serritella, P.C.	01/28/13	244	
Ashman & Stein	02/28/13	1,192	
Burke, Warren, MacKay & Serritella, P.C.	02/28/13	186	
Ashman & Stein	03/31/13	195	
Burke, Warren, MacKay & Serritella, P.C.	03/31/13	328	
Ashman & Stein	04/09/13	433	
Burke, Warren, MacKay & Serritella, P.C.	04/30/13	209	
Ashman & Stein	05/22/13	199	
Williams Montgomery & John, Ltd.	05/22/13	350	
Burke, Warren, MacKay & Serritella, P.C.	05/31/13	241	
Williams Montgomery & John, Ltd.	06/27/13	335	
Chuhak & Tecson, P.C.	06/28/13	1,040	
Burke, Warren, MacKay & Serritella, P.C.	06/30/13	427	
Hall, Prangle & Schoonveld, LLC	06/30/13	323	323
Meyer Magence	06/30/13	894	894
Simandl Law Group, S.C.	06/30/13	892	892
Ashman & Stein	07/23/13	1,073	
Burke, Warren, MacKay & Serritella, P.C.	07/23/13	280	
Ashman & Stein	08/27/13	119	
Burke, Warren, MacKay & Serritella, P.C.	08/27/13	415	
Williams Montgomery & John, Ltd.	08/27/13	1,346	
Jackson Lewis, LLP	08/27/13	1,248	
Ashman & Stein	08/30/13	(715)	
Simandl Law Group, S.C.	08/31/13	211	211
Ashman & Stein	09/23/13	303	
Williams Montgomery & John, Ltd.	09/23/13	1,058	
Burke, Warren, MacKay & Serritella, P.C.	09/30/13	699	
Ashman & Stein	10/23/13	650	
Burke, Warren, MacKay & Serritella, P.C.	10/28/13	166	
Robbins, Salomon & Patt, Ltd.	11/15/13	613	
Ashman & Stein	11/18/13	252	
Burke, Warren, MacKay & Serritella, P.C.	11/18/13	802	
Williams Montgomery & John, Ltd.	11/30/13	3,154	
Hall, Prangle & Schoonveld, LLC	11/30/13	323	323
Hall, Prangle & Schoonveld, LLC	11/30/13	1,227	1,227
Burke, Warren, MacKay & Serritella, P.C.	12/17/13	300	
Hall, Prangle & Schoonveld, LLC	12/31/13	2,795	2,795
Hall, Prangle & Schoonveld, LLC	12/31/13	1,029	1,029
Williams Montgomery & John, Ltd.	12/31/13	261	
Total		25,375	7,692
Non-Allowable			17,683

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	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 Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/13

Ending: 12/31/13

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? 5 - 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 10 - 02
- (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. \$ 240,620
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