



Facility Name & ID Number Park House Nrsng & Rehab Ctr

# 0050740 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		54	3,732	3,786	8
9	SNF/PED					9
10	ICF	30,994			30,994	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,994	54	3,732	34,780	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.89%

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 3,572

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsng & Rehab Ctr # 0050740 Report Period Beginning: 01/01/14 Ending: 12/31/14

**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
	<b>A. General Services</b>										
1	Dietary	217,490	19,555	6,646	243,691		243,691	685	244,376		1
2	Food Purchase		176,985		176,985		176,985	(1,736)	175,249		2
3	Housekeeping	185,245	26,343		211,588		211,588	389	211,977		3
4	Laundry	45,695	10,751	1,370	57,816		57,816		57,816		4
5	Heat and Other Utilities			93,491	93,491		93,491	873	94,364		5
6	Maintenance	40,819		229,128	269,947		269,947	11,050	280,997		6
7	Other (specify):* <a href="#">See Supplemental</a>	36,150			36,150		36,150	803	36,953		7
8	<b>TOTAL General Services</b>	525,399	233,634	330,635	1,089,668		1,089,668	12,064	1,101,732		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,183,001	73,822	11,042	1,267,865		1,267,865	5,271	1,273,136		10
10a	Therapy	95,005			95,005		95,005		95,005		10a
11	Activities	71,900	12,573	2,121	86,594		86,594	(748)	85,846		11
12	Social Services	298,250	29,948	1,301	329,499		329,499	2,388	331,887		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <a href="#">See Supplemental</a>							874	874		15
16	<b>TOTAL Health Care and Programs</b>	1,648,156	116,343	38,464	1,802,963		1,802,963	7,785	1,810,748		16
	<b>C. General Administration</b>										
17	Administrative	189,234			189,234		189,234	24,615	213,849		17
18	Directors Fees										18
19	Professional Services			277,903	277,903	(6,293)	271,610	(143,498)	128,112		19
20	Dues, Fees, Subscriptions & Promotions			27,610	27,610		27,610	(12,257)	15,353		20
21	Clerical & General Office Expenses	111,204	16,268	640,620	768,092		768,092	(549,416)	218,676		21
22	Employee Benefits & Payroll Taxes			442,599	442,599		442,599	(1,623)	440,976		22
23	Inservice Training & Education										23
24	Travel and Seminar			770	770		770	354	1,124		24
25	Other Admin. Staff Transportation			13,938	13,938		13,938	953	14,891		25
26	Insurance-Prop.Liab.Malpractice			123,026	123,026		123,026	1,089	124,115		26
27	Other (specify):* <a href="#">See Supplemental</a>							17,588	17,588		27
28	<b>TOTAL General Administration</b>	300,438	16,268	1,526,466	1,843,172	(6,293)	1,836,879	(662,195)	1,174,684		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,473,993	366,245	1,895,565	4,735,803	(6,293)	4,729,510	(642,346)	4,087,164		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**Park House Nursing & Rehab Center, LLC  
 Medicaid Cost Report  
 01/01/14 - 12/31/14**

**Page 3 Supplemental Schedule**

Description	Salaries	Supplies	Other
<b>Line 7 Detailed</b>			
Security	36,150		
Alloc. - Extended Care Consulting, LLC			803
Total	36,150	-	803

**Line 15 Detailed**

Total	-	-	-
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**Line 27 Detailed**

Alloc. - Extended Care Consulting, LLC			17,588
Total	-	-	17,588

**Park House Nursing & Rehab Center, LLC**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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**Page 3 Supplemental Schedule - Other Admin. Staff Transportation**

<u>Vendor</u>	<u>Amount</u>	<u>Allowable</u>
Care Consultants of Illinois	2,401	2,401
Elimelech Ray	1,549	1,549
Enterprise Fleet Management	149	149
Sonia Navar	43	43
Care Management Facility	892	892
Lorena Robledo-Sommerfield	2,145	2,145
Laura Feliciano Dixon	311	311
Laura Sepessy	103	103
Countryside	5,509	5,509
Other	837	837
Alloc. - Extended Care Consulting	953	953
Total	<u>14,891</u>	<u>14,891</u>

**Park House Nursing & Rehab Center, LLC**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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**Page 3 Supplemental Schedule - Reclass**

Description	Cost Center	Increase	Decrease
Real Estate Taxes	33	6,293	
Professional Fees	19		6,293

Facility Name &amp; ID Number

Park House Nrsg &amp; Rehab Ctr

#0050740

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	
	<b>D. Ownership</b>											
30	Depreciation			27,011	27,011		27,011	3,308	30,319			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,213	13,213		13,213	29,147	42,360			32
33	Real Estate Taxes			144,772	144,772	6,293	151,065	(9,136)	141,929			33
34	Rent-Facility & Grounds			343,645	343,645		343,645	(342,000)	1,645			34
35	Rent-Equipment & Vehicles			17,055	17,055		17,055	560	17,615			35
36	Other (specify):* See Supplemental											36
37	<b>TOTAL Ownership</b>			545,696	545,696	6,293	551,989	(318,121)	233,868			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,918	414,589	602,507		602,507	(103)	602,404			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,192	198,192		198,192		198,192			42
43	Other (specify):* See Supplemental											43
44	<b>TOTAL Special Cost Centers</b>		187,918	612,781	800,699		800,699	(103)	800,596			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,473,993	554,163	3,054,042	6,082,198		6,082,198	(960,570)	5,121,628			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

**Park House Nursing & Rehab Center, LLC**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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**Page 4 Supplemental Schedule**

Description	Salaries	Supplies	Other
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**Line 36 Detailed**

Total	-	-	-
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**Line 43 Detailed**

Total	-	-	-
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**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				9
10	Interest and Other Investment Income	(1,610)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,240)	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	(4,940)	21		18
19	Entertainment				19
20	Contributions	(1,175)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(598,193)	21		24
25	Fund Raising, Advertising and Promotional	(12,353)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,536)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(60,041)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (689,088)</b>		<b>\$</b>	<b>30</b>

**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)	(271,482)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (271,482)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	<b>\$ (960,570)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

## Park House Nrsg &amp; Rehab Ctr

ID# 0050740

Report Period Beginning: 01/01/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (6,360)	21	1
2	Patient Clothing	(748)	11	2
3	Collections	(2,244)	19	3
4	Bank Charges	(13,157)	21	4
5	Theft Loss	(55)	21	5
6	Settlement	(4,125)	21	6
7	Other Professional	(3,567)	19	7
8	Legal	(12,977)	19	8
9	RE Tax Refund Adjustment	(11,034)	33	9
10				10
11				11
12				12
13				13
14	2320 South Lawndale, LLC			14
15	Professional Fees	(1,325)	19	15
16	Office and Clerical	(250)	21	16
17	Amortization	(4,199)	31	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	<b>Total</b>	(60,041)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	0	0	113	0	0	0	572	0	0	0	0	685	1
2	Food Purchase	(2,240)	0	504	0	0	0	0	0	0	0	0	(1,736)	2
3	Housekeeping	0	0	377	0	0	12	0	0	0	0	0	389	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	851	0	0	22	0	0	0	0	0	873	5
6	Maintenance	0	0	3,513	7,519	0	18	0	0	0	0	0	11,050	6
7	Other (specify):*	0	0	0	738	0	0	65	0	0	0	0	803	7
8	<b>TOTAL General Services</b>	<b>(2,240)</b>	<b>0</b>	<b>5,358</b>	<b>8,257</b>	<b>0</b>	<b>52</b>	<b>637</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,064</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	0	0	5,271	0	0	0	0	5,271	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(748)	0	0	0	0	0	0	0	0	0	0	(748)	11
12	Social Services	0	0	0	0	0	0	2,388	0	0	0	0	2,388	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	874	0	0	0	0	874	15
16	<b>TOTAL Health Care and Programs</b>	<b>(748)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,533</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,785</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	2,334	12,621	0	0	9,660	0	0	0	0	24,615	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,113)	1,325	(123,474)	0	0	(1,236)	0	0	0	0	0	(143,498)	19
20	Fees, Subscriptions & Promotions	(13,528)	0	1,240	0	0	31	0	0	0	0	0	(12,257)	20
21	Clerical & General Office Expenses	(635,616)	250	8,492	74,056	0	176	3,226	0	0	0	0	(549,416)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(1,623)	0	0	0	0	0	0	0	(1,623)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	194	0	0	160	0	0	0	0	0	354	24
25	Other Admin. Staff Transportation	0	0	953	0	0	0	0	0	0	0	0	953	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,025	0	0	64	0	0	0	0	0	1,089	26
27	Other (specify):*	0	0	0	17,588	0	0	0	0	0	0	0	17,588	27
28	<b>TOTAL General Administration</b>	<b>(669,257)</b>	<b>1,575</b>	<b>(109,236)</b>	<b>102,642</b>	<b>0</b>	<b>(805)</b>	<b>12,886</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(662,195)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(672,245)</b>	<b>1,575</b>	<b>(103,878)</b>	<b>110,899</b>	<b>0</b>	<b>(753)</b>	<b>22,056</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(642,346)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park House Nrsg & Rehab Ctr # 0050740 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	3,158	0	0	150	0	0	0	0	0	3,308	30
31	Amortization of Pre-Op. & Org.	(4,199)	4,199	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,610)	25,776	723	0	0	4,258	0	0	0	0	0	29,147	32
33	Real Estate Taxes	(11,034)	0	1,841	0	0	57	0	0	0	0	0	(9,136)	33
34	Rent-Facility & Grounds	0	(342,000)	0	0	0	0	0	0	0	0	0	(342,000)	34
35	Rent-Equipment & Vehicles	0	0	560	0	0	0	0	0	0	0	0	560	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(16,843)</b>	<b>(312,025)</b>	<b>6,282</b>	<b>0</b>	<b>0</b>	<b>4,465</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(318,121)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	(103)	0	0	(103)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(103)</b>	<b>0</b>	<b>0</b>	<b>(103)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(689,088)</b>	<b>(310,450)</b>	<b>(97,596)</b>	<b>110,899</b>	<b>0</b>	<b>3,712</b>	<b>22,056</b>	<b>0</b>	<b>(103)</b>	<b>0</b>	<b>0</b>	<b>(960,570)</b>	<b>45</b>

**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
<a href="#">See Page 6 Supp</a>		<a href="#">See Page 6 - Supp</a>		<a href="#">See Page 6 - Supp</a>		

**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	\$ 342,000	2320 South Lawndale, LLC	100.00%	\$	\$ (342,000)	1
2	V	32	Interest		2320 South Lawndale, LLC	100.00%			2
3	V	19	Professional Fees		2320 South Lawndale, LLC	100.00%	1,325	1,325	3
4	V	21	Office		2320 South Lawndale, LLC	100.00%	250	250	4
5	V	26	Property Insurance		2320 South Lawndale, LLC	100.00%			5
6	V	30	Depreciation		2320 South Lawndale, LLC	100.00%			6
7	V	31	Amortization		2320 South Lawndale, LLC	100.00%	4,199	4,199	7
8	V	32	Interest	129,635	2320 South Lawndale, LLC	100.00%	155,411	25,776	8
9	V	33	Real Estate Taxes	144,806	2320 South Lawndale, LLC	100.00%	144,806		9
10	V	36	Mortgage Insurance Premiums		2320 South Lawndale, LLC	100.00%			10
11	V								11
12	V								12
13	V								13
14	Total		\$ 616,441				\$ 305,991	\$ * (310,450)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Park House Nrsg &amp; Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Rothner Family Grandchildren Trust	10.00%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. 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			South Suburban Rehabilitation Center	Chicago, IL	2320 South			11
12			Tri-State Nursing and Rehab	Lansing, IL	Lawndale, LLC	Chicago, IL	Bldg. Company	12
13			Wheaton Care Center	Wheaton, IL				13
14			Kensington Place Nursing and Rehab	Chicago, IL				14
15			Countryside Nursing and Rehab	Dolton, IL				15
16			Spring Creek Nursing and Rehab	Joliet, IL				16
17			Park House Nursing and Rehab	Chicago, IL				17
18			Timber Point Healthcare Center	Camp Point, IL				18
19			Prairie Village Healthcare Center	Jacksonville, IL				19
20			Major Hospital - Dyer	Dyer, IN				20
21			Major Hospital - Lake County	East Chicago, IN				21
22			Major Hospital - Sebo	Holbart, IN				22
23			Major Hospital - Lincolnshire	Merrillville, IN				23
24			Major Hospital - Munster	Munster, IN				24
25			McKinley Health Care Center	Canton, OH				25
26			St. James Manor	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				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	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 113	\$ 113	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	504	504	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	377	377	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	851	851	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	3,513	3,513	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,334	2,334	20
21	V	19 Professional Fees	130,131	Extended Care Consulting, LLC	100.00%	6,657	(123,474)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,240	1,240	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	8,492	8,492	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	194	194	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	953	953	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,025	1,025	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,158	3,158	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	723	723	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,841	1,841	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	560	560	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		\$ 130,131			\$ 32,535	\$ * (97,596)	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	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 6,053	\$	6,053	15
16	V	6 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	1,466		1,466	16
17	V	7 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	574		574	17
18	V	7 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	164		164	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	12,621		12,621	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	74,056		74,056	20
21	V	21 Office and Clerical (Direct)	17,007	Extended Care Consulting, LLC	100.00%	17,007			21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,965		15,965	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,623		1,623	23
24	V	22 Employee Benefits	1,623					(1,623)	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		\$ 18,630			\$ 129,529	\$ *	110,899	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	\$ 372	Care Centers Health Systems, Inc.	100.00%	\$ 372	\$
16	V	10 Nursing	56	Care Centers Health Systems, Inc.	100.00%	56	
17	V	39 Ancillary	726	Care Centers Health Systems, Inc.	100.00%	726	
18	V						
19	V						
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	<b>Total</b>		\$ 1,154			\$ 1,154	\$ *

\* 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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 12	\$	12	15
16	V	05 Utilitis		Extended Care Clinical, LLC	100.00%	22		22	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	18		18	17
18	V	19 Professional Fees	1,350	Extended Care Clinical, LLC	100.00%	114		(1,236)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	31		31	19
20	V	21 Office and Clerical		Extended Care Clinical, LLC	100.00%	176		176	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	160		160	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	64		64	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	150		150	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	4,258		4,258	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	57		57	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		\$ 1,350			\$ 5,062	\$ *	3,712	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	01 Dietary Salary	\$	Extended Care Clinical, LLC	100.00%	\$ 572	\$	572	15
16	V	07 Emp. Ben. - Gen. Services		Extended Care Clinical, LLC	100.00%	65		65	16
17	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	5,271		5,271	17
18	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	2,388		2,388	18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	874		874	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	8,340		8,340	20
21	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	3,226		3,226	21
22	V	17 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	1,320		1,320	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		\$			\$ 22,056	\$ *	22,056	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	22 Employee Benefits	\$ 86,254	CCS VEBA	100.00%	\$ 86,254	\$	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		\$ 86,254			\$ 86,254	\$ *	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	\$ 1,160	Vent Lease, LLC	100.00%	\$ 1,057	\$	(103)	15
16	V	32 Interest		Vent Lease, LLC	100.00%				16
17	V	30 Depreciation		Vent Lease, LLC	100.00%				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		\$ 1,160			\$ 1,057	\$ *	(103)	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: 01/01/14 Ending: 12/31/14

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	0.74	1.85%	Salary	\$ 452	22 - 7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 452		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:

01/01/14

Ending: 12/31/14

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	1	Dietary	Patient Days	1,251,572	31	\$ 4,057	\$ 34,780	\$ 113	1
2	2	Food	Patient Days	1,251,572	31	18,150	34,780	504	2
3	3	Housekeeping	Patient Days	1,251,572	31	13,578	34,780	377	3
4	5	Utilities	Patient Days	1,251,572	31	30,626	34,780	851	4
5	6	Maintenance	Patient Days	1,251,572	31	126,400	34,780	3,513	5
6	17	Administrative	Patient Days	1,251,572	31	84,000	34,780	2,334	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560	34,780	6,657	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626	34,780	1,240	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586	34,780	8,492	9
10	24	Travel and Seminar	Patient Days	1,251,572	31	6,989	34,780	194	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307	34,780	953	11
12	26	Insurance	Patient Days	1,251,572	31	36,877	34,780	1,025	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642	34,780	3,158	13
14	32	Interest	Patient Days	1,251,572	31	26,010	34,780	723	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240	34,780	1,841	15
16	35	Rent - Equipment and Auto	Patient Days	1,251,572	31	20,168	34,780	560	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,170,816	\$	\$ 32,535	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsng & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	6	Maintenance	Patient Days	1,251,572	31	\$ 217,811	\$ 217,811	34,780	\$ 6,053	1
2	6	Maintenance	Direct	1	1	1,466	1,466	1	1,466	2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,251,572	31	20,665		34,780	574	3
4	7	Emp. Ben. - Gen. Serv.	Direct	1	1	164		1	164	4
5	17	Administrative	Patient Days	1,251,572	31	454,189	454,189	34,780	12,621	5
6	21	Office and Clerical	Patient Days	1,251,572	31	2,664,950	2,664,951	34,780	74,056	6
7	21	Office and Clerical	Direct	1	1	17,007	17,007	1	17,007	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,251,572	31	574,509	574,509	34,780	15,965	8
9	27	Emp. Gen. - Gen. Admin.	Direct	1	1	1,623		1	1,623	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,952,384	\$ 3,929,933		\$ 129,529	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 %	77,896	21	\$ 77,896	\$ 372	\$ 372	1
2	10	Nursing	Profit Margin %	234	21	234	56	56	2
3	39	Ancillary	Profit Margin %	97,004	21	97,004	726	726	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					\$ 175,134	\$	\$ 1,154	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Clinical, 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	03	Housekeeping	Management Fees	758,409	19	\$ 1,549	\$ 5,729	\$ 12	1
2	05	Utilitis	Management Fees	758,409	19	2,849	5,729	22	2
3	06	Maintenance	Management Fees	758,409	19	2,348	5,729	18	3
4	19	Professional Fees	Management Fees	758,409	19	15,090	5,729	114	4
5	20	Dues and Subscriptions	Management Fees	758,409	19	4,042	5,729	31	5
6	21	Office and Clerical	Management Fees	758,409	19	23,285	5,729	176	6
7	24	Travel and Seminar	Management Fees	758,409	19	21,158	5,729	160	7
8	26	Insurance	Management Fees	758,409	19	8,431	5,729	64	8
9	30	Depreciation	Management Fees	758,409	19	19,889	5,729	150	9
10	32	Interest	Management Fees	758,409	19	563,670	5,729	4,258	10
11	33	Real Estate Taxes	Management Fees	758,409	19	7,558	5,729	57	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					\$ 669,869	\$ 5,062		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsng & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Clinical, 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 Salary	758,409	19	\$ 75,731	\$ 75,731	5,729	\$ 572	1
2	07	Emp. Ben. - Gen. Services	758,409	19	8,645		5,729	65	2
3	10	Nursing Salary	758,409	19	697,742	697,742	5,729	5,271	3
4	12	Social Service Salary	758,409	19	316,078	316,078	5,729	2,388	4
5	15	Emp. Ben. - Healthcare	758,409	19	115,731		5,729	874	5
6	17	Administration Salary	758,409	19	1,104,097	1,104,097	5,729	8,340	6
7	21	Office Salary	758,409	19	427,044	427,044	5,729	3,226	7
8	17	Emp. Ben. - Gen. Admin.	758,409	19	174,785		5,729	1,320	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				\$ 2,919,853	\$ 2,620,692		\$ 22,056	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	Direct Allocations	1	1	\$ 86,254	\$	1	\$ 86,254	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					\$ 86,254	\$		\$ 86,254	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Vent Lease, 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	39	Ancillary	Profit Margin %	110,244	18	\$ 110,244	\$ 1,057	\$ 1,057	1
2	32	Depreciation	Direct	2,695	1	2,695			2
3	30	Interest	Direct	2,944	1	2,944			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					\$ 115,883	\$	\$ 1,057	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr # 0050740 Report Period Beginning: 01/01/14 Ending: 12/31/14

**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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Talmer Bank		X	Mortgage			\$	\$ 3,042,910			\$	155,411	1				
2													2				
3													3				
4													4				
5													5				
<b>Working Capital</b>																	
6	HFG		X	Line of Credit								13,213	6				
7	Alloc. - Extended Care Con.	X		Line of Credit								723	7				
8	Alloc. - Extended Care Clin.	X		Line of Credit								4,258	8				
9	TOTAL Facility Related						\$	\$ 3,042,910			\$	173,605	9				
<b>B. Non-Facility Related*</b>																	
10													10				
11													11				
12	Interest Income		X									(1,610)	12				
13	Interest Income - Bldg. Part.		X									(129,635)	13				
14	TOTAL Non-Facility Related						\$	\$			\$	(131,245)	14				
15	TOTALS (line 9+line14)						\$	\$ 3,042,910			\$	42,360	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # 36

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



**2013 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Park House Nrsng & Rehab Ctr COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0050740  
 CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA  
 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 2013 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 2013.

(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>41,057.66</u>	\$ <u>41,057.66</u>
2. <u>16-26-105-079-0000</u>	<u>Long Term Care Facility</u>	\$ <u>50,808.49</u>	\$ <u>50,808.49</u>
3. <u>16-26-105-080-0000</u>	<u>Long Term Care Facility</u>	\$ <u>50,902.36</u>	\$ <u>50,902.36</u>
4. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>162,082.08</u>	\$ <u>1,753.11</u>
5. <u>Alloc. - Ext. Care Clinical</u>	<u>Long Term Care Facility</u>	\$ <u>162,082.08</u>	\$ <u>54.38</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>466,932.67</u></u>	\$ <u><u>144,576.00</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

**Park House Nursing & Rehab Center, LLC  
 Medicaid Cost Report  
 01/01/14 - 12/31/14**

**Page 10 Supplemental Schedule**

<b>Vendor</b>	<b>Description</b>	<b>Amount</b>
<b>Appeal Costs</b>		
Finkel, Martwick & Colson, P.C.	2011 - Tax Refund Legal Fees	4,119
Finkel, Martwick & Colson, P.C.	2012 - Tax Reduction Legal Fees	2,174
Total - Line 5 Total		6,293
<b>Refunds</b>		
Total		-
<b>Refund Adjustment</b>		
Appeal Costs		6,293
Real Estate Tax Refund	15,775	
Appeal Costs	6,293	
Remainder	9,482	
1/2 of Remainder		4,741
Total - Line 6 Total		11,034

Facility Name & ID Number Park House Nrsg & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14 Ending:

12/31/14

**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).

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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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 40,650	1
2	Alloc. - Ext. Care			9,144	2
3	TOTALS			\$ 49,794	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		1989		\$ 1,209,350	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Park House Nursing & Rehab Center, LLC										
10											10
11	Various		1989		21,943						11
12	Various		1990		11,700						12
13	Various		1991		17,413						13
14	Various		1992		55,138						14
15	Various		1993		26,399						15
16	Various		1994		3,400						16
17	Various		1995		1,500						17
18	Various		1996		106,964						18
19	Various		1997		28,175						19
20	Various		1998		114,780						20
21	Various		1999		41,539						21
22	Various		2000		7,413						22
23	Various		2001		12,564						23
24	Various		2002		13,922						24
25	Various		2003		28,642						25
26	Various		2004		10,025						26
27	Various		2005		45,846						27
28	Various		2006		40,248						28
29	Various		2007		33,310						29
30	Various		2008		25,390						30
31	Various		2009		154,704						31
32	Water Heater and Roof Exhaust		2011		8,534	427		427		1,494	32
33	Six Deley Egress Doors		2011		4,630	926		926		3,010	33
34	Electrical Circuits with 2 Outlets		2013		3,500	127		127		244	34
35	Fire Dampers		2013		3,900	142		142		236	35
36	Hollow Metal Doors and Steel Frames		2013		5,228	190		190		323	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	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		
37	<u>Park House Nursing &amp; Rehab Center, LLC (Continued)</u>		\$	\$		\$	\$		37
38									38
39	<u>Floor Drain - Sprinkler Room</u>	<u>2013</u>	<u>6,650</u>	<u>242</u>		<u>242</u>		<u>242</u>	39
40	<u>Conduit, Relay, and Annunciator Panel</u>	<u>2013</u>	<u>2,983</u>	<u>108</u>		<u>108</u>		<u>108</u>	40
41	<u>Kitchen Exhaust Hood</u>	<u>2014</u>	<u>3,000</u>	<u>100</u>		<u>100</u>		<u>100</u>	41
42	<u>Elevator Repairs - Valves and Components</u>	<u>2014</u>	<u>9,500</u>	<u>58</u>		<u>58</u>		<u>58</u>	42
43	<u>Sewer Repairs - Rebuild</u>	<u>2014</u>	<u>2,800</u>	<u>8</u>		<u>8</u>		<u>8</u>	43
44	<u>Dumbwaiter - Doors, Cables, Switches, &amp; Chains</u>	<u>2014</u>	<u>2,322</u>	<u>7</u>		<u>7</u>		<u>7</u>	44
45	<u>Sewer Repairs - Rebuild</u>	<u>2014</u>	<u>2,800</u>	<u>8</u>		<u>8</u>		<u>8</u>	45
46	<u>Dumbwaiter - Doors, Cables, Switches, &amp; Chains</u>	<u>2014</u>	<u>5,468</u>						46
47	<u>Roof Repairs (Net of Insurance Proceeds)</u>	<u>2014</u>	<u>10,394</u>	<u>79</u>		<u>79</u>		<u>79</u>	47
48	<u>AC Unit - Mechanical Repair</u>	<u>2014</u>	<u>2,993</u>	<u>1,796</u>		<u>1,796</u>		<u>1,796</u>	48
49	<u>Elevator Repairs - Valves and Components</u>	<u>2014</u>	<u>4,200</u>	<u>2,520</u>		<u>2,520</u>		<u>2,520</u>	49
50	<u>Elevator Repairs - Valves and Components</u>	<u>2014</u>	<u>3,800</u>	<u>2,280</u>		<u>2,280</u>		<u>2,280</u>	50
51	<u>Dumbwaiter - Replace broken hoist cable</u>	<u>2014</u>	<u>3,150</u>	<u>1,890</u>		<u>1,890</u>		<u>1,890</u>	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	<b>TOTAL (lines 4 thru 69)</b>		<b>\$ 2,096,217</b>	<b>\$ 10,908</b>		<b>\$ 10,908</b>	<b>\$</b>	<b>\$ 14,403</b>	<b>70</b>

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,096,217	\$ 10,908		\$ 10,908	\$	\$ 14,403	1
2	<b>Related Party Allocations - See Supplemental Schedules</b>								2
3									3
4	Allocations - Extended Care Consulting, LLC	2007	128	6	6		51	4	
5	Allocations - Extended Care Consulting, LLC	2009	76	4	4		23	5	
6	Allocations - Extended Care Consulting, LLC	2010	750	37	37		187	6	
7	Allocations - Extended Care Consulting, LLC	2011	270	13	13		54	7	
8	Allocations - Extended Care Consulting, LLC	2013	89	4	4		13	8	
9	Allocations - Extended Care Consulting, LLC	2014	1,232	62	62		62	9	
10								10	
11								11	
12	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	12,222	313	313		3,852	12	
13	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	10,096	861	861		10,096	13	
14	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	11,898	1,014	1,014		11,898	14	
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	591	63	63		527	15	
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	107	5	5		32	16	
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	1,704	85	85		85	17	
18								18	
19								19	
20	Allocations - Extended Care Clinical, LLC / 2201 Main, LLC	2002	379	10	10		119	20	
21	Allocations - Extended Care Clinical, LLC / 2201 Main, LLC	2002	313	27	27		313	21	
22	Allocations - Extended Care Clinical, LLC / 2201 Main, LLC	2003	369	31	31		369	22	
23	Allocations - Extended Care Clinical, LLC / 2201 Main, LLC	2005	18	2	2		16	23	
24	Allocations - Extended Care Clinical, LLC / 2201 Main, LLC	2009	3				1	24	
25	Allocations - Extended Care Clinical, LLC / 2201 Main, LLC	2014	53	3	3		3	25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,136,515	\$ 13,448		\$ 13,448	\$	\$ 42,104	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	\$ 43,734	\$ 8,835	\$ 8,835	\$	5 - 7	\$ 19,786	71
72	Current Year Purchases	15,170	7,268	7,268		5	7,268	72
73	Fully Depreciated Assets							73
74	See Supplemental	287,734	548	548			284,245	74
75	TOTALS	\$ 346,638	\$ 16,651	\$ 16,651	\$		\$ 311,299	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	Alloc. - Ext. Care Consult.			\$ 5,015	\$ 142	\$ 142	\$		\$ 4,448	76
77	Alloc. - Ext. Care Clinical			388	78	78			192	77
78										78
79										79
80	TOTALS			\$ 5,403	\$ 220	\$ 220	\$		\$ 4,640	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 2,538,350	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,319	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,319	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)	\$ 358,043	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 Nursing & Rehab Center, LLC  
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**Page 13 Supplemental Schedule**

Description	Cost	Depreciation	Accumulated Depreciation
<b>Related Party 1 - 2320 S. Lawndale, LLC</b>			
Prior	200,000		200,000
Current			
Total	200,000	-	200,000
<b>Related Party 2 - Extended Care Consulting, LLC</b>			
Prior	82,188	342	80,549
Current	2,056	206	206
Total	84,244	548	80,755
<b>Related Party 3 - Extended Care Consulting, LLC / 2201 Main, LLC</b>			
Prior	3,385		3,385
Current			
Total	3,385	-	3,385
<b>Related Party 4 - Extended Care Clinical, LLC / 2201 Main, LLC</b>			
Prior	105		105
Current			
Total	105	-	105
<b>Total</b>	<b>287,734</b>	<b>548</b>	<b>284,245</b>

**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?  YES  NO  
 If NO, see instructions.

		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				1,645			6
7	TOTAL				\$ 1,645			7

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>/2015</u>	\$ _____
13.	<u>/2016</u>	\$ _____
14.	<u>/2017</u>	\$ _____

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: \$ 13,111 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	<u>Facility</u>	<u>Infinity</u>	\$ _____	\$ <u>4,504</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>4,504</u>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**Park House Nursing & Rehab Center, LLC**  
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**Page 14 Supplemental Schedule - Building and Fixed Equipment**

<b>Vendor</b>	<b>Amount</b>
Public Storage	1,248
Total	<u>1,248</u>

**Page 14 Supplemental Schedule - Equipment Rental**

<b>Vendor</b>	<b>Amount</b>
Hughes Enterprises	8,220
Wells Fargo	3,532
Chicago Office Technology	614
Other	185
Alloc. - Extended Care Consulting, LLC	560
Total	<u>13,111</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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 of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	196,783	\$		\$	196,783	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				12,860				12,860	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				198,316				198,316	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					181,070			181,070	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <a href="#">See Supplemental</a>	39 - 02						6,848			6,848	12
13	Other (specify): <a href="#">See Supplemental</a>	39 - 03					6,630				6,630	13
14	TOTAL			\$		\$	414,589	\$	187,918	\$	602,507	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  
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**Page 16 Supplemental Schedule**

<u>Description</u>	<u>Supplies</u>	<u>Other</u>
Medical Supplies	2,436	
Oxygen	3,130	
Other	1,282	
Wheelchairs and Walkers		704
Food Pump		381
Laboratory		3,736
Radiology		1,809
Total	<u>6,848</u>	<u>6,630</u>

Facility Name & ID Number Park House Nrsg & Rehab Ctr# 0050740Report Period Beginning: 01/01/14Ending: 12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 282	\$ 37,564	1
2	Cash-Patient Deposits	29,960	29,960	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>910,620</u> )	1,196,566	1,196,566	3
4	Supply Inventory (priced at <u>Cost - FIFO</u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,643	40,643	6
7	Other Prepaid Expenses	83,554	83,554	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	408	408	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,351,413	\$ 1,388,695	10
<b>B. Long-Term Assets</b>				
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	74,128	226,945	15
16	Equipment, at Historical Cost	73,048	273,048	16
17	Accumulated Depreciation (book methods)	(41,456)	(1,414,993)	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>		1,027,215	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 105,720	\$ 1,173,585	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,457,133	\$ 2,562,280	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,130,189	\$ 1,130,189	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,945	17,945	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,340	116,340	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,566	5,566	31
32	Accrued Real Estate Taxes(Sch.IX-B)		149,907	32
33	Accrued Interest Payable		12,450	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Supplemental Schedule</u>	312,314		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,582,354	\$ 1,432,397	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,042,910	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Supplemental Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 3,042,910	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,582,354	\$ 4,475,307	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (125,221)	\$ (1,913,027)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,457,133	\$ 2,562,280	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Park House Nrsg & Rehab Ctr  
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**Page 17 Supplemental Schedule**

Description	Operating	After Consolidation
<b>Line 9 - Other Current Assets</b>		
Due from Employees	408	408
Total	408	408
<b>Line 23 - Other Long Term Assets</b>		
Real Estate Escrow		56,750
Replacement Reserve		3,092
Financing Costs (Net of Amortization)		16,444
Due from Related Parties		950,929
Total	-	1,027,215
<b>Line 36 - Other Current Liabilities</b>		
Due from Related Parties	312,314	
Total	312,314	-
<b>Line 43 - Other Long Term Liabilities</b>		
Total	-	-

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>163,543</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>163,543</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(288,764)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(288,764)</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(125,221)</b>	<b>24</b> *

\* 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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,707,986	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,707,986	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	61,703	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 61,703	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,610	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,610	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	22,135	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 22,135	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,793,434	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,089,668	31
32	Health Care	1,802,963	32
33	General Administration	1,843,172	33
<b>B. Capital Expense</b>			
34	Ownership	545,696	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	602,507	35
36	Provider Participation Fee	198,192	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,082,198	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(288,764)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (288,764)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,753,517	44
45	Private Pay - Net Inpatient Revenue	13,740	45
46	Medicare - Net Inpatient Revenue	1,850,926	46
47	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	10,655	47
48	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	79,148	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,707,986	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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**

**Park House Nrsg & Rehab Ctr  
Medicaid Cost Report  
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**Page 19 Supplemental Schedule**

Description	Total	Adjustment
<b>Line 28 - Other Revenue</b>		
Other Income	6,360	6,360
Real Estate Tax Refund	15,775	15,775
Total	<u>22,135</u>	<u>22,135</u>

Facility Name & ID Number Park House Nrsg & Rehab Ctr

# 0050740

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	2,013	2,160	\$ 96,269	\$ 44.57	1
2	Assistant Director of Nursing	1,919	2,282	79,659	34.91	2
3	Registered Nurses	5,861	6,486	195,525	30.15	3
4	Licensed Practical Nurses	13,370	14,050	364,163	25.92	4
5	CNAs & Orderlies	35,903	40,083	417,312	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,924	4,769	95,005	19.92	8
9	Activity Director	1,869	2,110	29,031	13.76	9
10	Activity Assistants	4,058	4,433	42,869	9.67	10
11	Social Service Workers	13,788	15,141	298,250	19.70	11
12	Dietician					12
13	Food Service Supervisor	1,898	2,129	48,153	22.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,938	16,139	169,337	10.49	15
16	Dishwashers					16
17	Maintenance Workers	1,875	2,047	40,819	19.94	17
18	Housekeepers	16,795	18,476	185,245	10.03	18
19	Laundry	3,762	4,276	45,695	10.69	19
20	Administrator	1,784	2,023	103,590	51.21	20
21	Assistant Administrator			63,536		21
22	Other Administrative	343	279	22,108	79.24	22
23	Office Manager					23
24	Clerical	4,216	4,289	111,204	25.93	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	1,877	2,134	30,073	14.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	3,766	4,071	36,150	8.88	33
34	TOTAL (lines 1 - 33)	132,959	147,377	\$ 2,473,993 *	\$ 16.79	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	\$ 6,646	01 - 03	35
36	Medical Director	24,000	09 - 03	36
37	Medical Records Consultant	2,246	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	8,796	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,121	11 - 03	44
45	Social Service Consultant	1,301	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 45,110		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				Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount					
Elimelech S. Ray (01/01 - 10/31)	Administrator	0	\$ 87,878	Workers' Compensation Insurance	\$ 81,683	IDPH License Fee	\$					
Laura Feliciano-Dixon (11/01 - 12/31)	Administrator	0	15,712	Unemployment Compensation Insurance	61,830	Advertising: Employee Recruitment	869					
Laura Feliciano-Dixon (01/01 - 10/31)	Asst. Admin.	0	63,536	FICA Taxes	191,355	Health Care Worker Background Check	6,825					
Sherwin Ray	Administration	0	22,108	Employee Health Insurance	86,254	(Indicate # of checks performed )						
				Employee Meals		<u>Patient Background Checks</u>						
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Public Relations	12,353					
				Employee Physicals	72	Dues and Subscriptions	1,041					
				Pension	16,774	Licenses	5,347					
				Other Employee Welfare	3,008	Alloc. - Extended Care Consulting	1,240					
						Alloc. - Extended Care Clinical	31					
						Less: Public Relations Expense	( )					
						Non-allowable advertising	(12,353)					
						Yellow page advertising	( )					
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		<b>\$ 15,353</b>				
<b>(List each licensed administrator separately.)</b>					<b>\$ 189,234</b>							
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	770				
							Alloc. - Extended Care Consulting	194				
							Alloc. - Extended Care Clinical	160				
							Entertainment Expense	( )				
							(agree to Sch. V, line 24, col. 8)					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>						<b>\$</b>	<b>TOTAL</b>	<b>\$ 1,124</b>				
<b>(Attach a copy of any management service agreement)</b>												
C. Professional Services												
Vendor/Payee	Type											
Extended Care Consulting, LLC	Home Office	\$	130,131									
Extended Care Clinical, LLC	Home Office		1,350									
Personnel Planners, Inc.	Unemployment Consultant		1,686									
Plante & Moran, PLLC	Accounting		17,875									
Krupnick, Bokor & Kagda	Accounting		1,000									
Frost, Ruttenger & Rothblatt, PC	Accounting		405									
Paycor Payroll Services	Data Processing / IT		15,459									
Medifax / EDI	Data Processing / IT		956									
E-Health Data Solutions	Data Processing / IT		6,490									
American Data	Data Processing / IT		4,494									
MDI / Achieve	Data Processing / IT		4,351									
See Supplemental Schedule			93,705									
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>						<b>\$</b>						
<b>(For legal fee disclosure, see page 39 of instructions)</b>												

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Park House Nursing & Rehab Center, LLC**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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**Page 21 Supplemental Schedule - Other Professional Fees**

Vendor	Type	Amount
Care Consultants of Illinois	Data Processing / IT	411
Matrixcare	Data Processing / IT	19,991
Singer Networks	Data Processing / IT	4,172
Care Management Facility	Data Processing / IT	3,602
Nebo Systems	Data Processing / IT	104
Paragon Micro	Data Processing / IT	1,606
National Datacare Corporation	Data Processing / IT	2,399
Ability Network	Data Processing / IT	2,752
Coburn Enterprises	Data Processing / IT	24
Smart Technology Services	Data Processing / IT	3,070
Other	Data Processing / IT	5,879
Burke, Warren, MacKay & Serritella, P.C.	Legal	913
Williams, Montgomery & John, Ltd.	Legal	3,134
Holly Turner	Legal	1,250
Roff Goffman	Legal	3
Chuhak & Tecsccon	Legal	921
Ashman & Stein	Legal	8,006
Foley & Lardner	Legal	1,602
Hall Prangle	Legal	68
Simandl Law Group	Legal	3,673
Finkel, Martwick & Colson, P.C.	Legal	4,119
Grabowski Law Services, LLC	Collections	2,244
HFG	Other	3,567
Blymas	Tax Accountant	1,025
Prospect Resources	Other	2,438
Terrill Consulting Services	Other	3,197
Finkel, Martwick & Colson, P.C.	RE Tax Reduction	2,174
Extended Care Consulting	Other	1,083
Legat Architects	Architects	688
Resource Utilization Xperts	Other	9,591
Total		93,705

**Park House Nrsg & Rehab Ctr  
Medicaid Cost Report  
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**Page 21 Supplemental Schedule - Legal Invoice Detail**

Firm Name	Invoice Date	Description of Services	Allowable Amount	Non-Allowable Amount
Williams, Montgomery & John, Ltd.	01/20/14	Non-Allowable		61
Ashman & Stein	01/23/14	Non-Allowable		260
Burke, Warren, MacKay & Serritella, P.C.	01/23/14	Non-Allowable		122
Williams, Montgomery & John, Ltd.	02/17/14	Non-Allowable		82
Ashman & Stein	02/19/14	Non-Allowable		983
Burke, Warren, MacKay & Serritella, P.C.	02/28/14	Non-Allowable		119
Burke, Warren, MacKay & Serritella, P.C.	03/27/14	Non-Allowable		36
Williams, Montgomery & John, Ltd.	03/28/14	Non-Allowable		73
Simandi Law Group	03/31/14	Labor & Employment	358	
Hall Prangle	04/29/14	Corporate Matters - JJ	68	
Simandi Law Group	04/30/14	Labor & Employment	488	
Williams, Montgomery & John, Ltd.	04/30/14	Non-Allowable		94
Williams, Montgomery & John, Ltd.	05/15/14	Non-Allowable		33
Burke, Warren, MacKay & Serritella, P.C.	05/18/14	Non-Allowable		99
Burke, Warren, MacKay & Serritella, P.C.	05/31/14	Non-Allowable		83
Scott Turner	05/31/14	Resident Guardianship	61	
Simandi Law Group	05/31/14	Labor & Employment	2,828	
Ashman & Stein	06/30/14	Non-Allowable		1,775
Williams, Montgomery & John, Ltd.	07/11/14	Non-Allowable		8
Burke, Warren, MacKay & Serritella, P.C.	07/23/14	Non-Allowable		13
Ashman & Stein	07/31/14	Non-Allowable		1,109
Chuhak & Tecson	07/31/14	Non-Allowable		247
Burke, Warren, MacKay & Serritella, P.C.	08/15/14	Non-Allowable		17
Ashman & Stein	08/27/14	Non-Allowable		1,014
Williams, Montgomery & John, Ltd.	09/25/14	Non-Allowable		947
Finkel, Martwick & Colson, P.C.	09/26/14	Real Estate Appeal	4,119	
Burke, Warren, MacKay & Serritella, P.C.	09/30/14	Non-Allowable		298
Holly Turner	09/30/14	Corporate Matters	250	
Burke, Warren, MacKay & Serritella, P.C.	10/09/14	Non-Allowable		26
Holly Turner	10/09/14	Corporate Matters	540	
Chuhak & Tecson	10/23/14	Non-Allowable		492
Chuhak & Tecson	10/31/14	Non-Allowable		178
Chuhak & Tecson	10/31/14	Non-Allowable		(186)
Chuhak & Tecson	10/31/14	Non-Allowable		89
Chuhak & Tecson	11/07/14	Non-Allowable		101
Foley & Lardner	11/07/14	Corporate Matters - Review Cost Reports	193	
Holly Turner	11/11/14	Corporate Matters	250	
Burke, Warren, MacKay & Serritella, P.C.	11/17/14	Non-Allowable		72
Ashman & Stein	11/20/14	Non-Allowable		1,289
Ashman & Stein	11/26/14	Non-Allowable		1,577
Roff Goffman	11/26/14	Non-Allowable		3
Williams, Montgomery & John, Ltd.	11/26/14	Non-Allowable		526
Williams, Montgomery & John, Ltd.	11/26/14	Non-Allowable		1,014
Williams, Montgomery & John, Ltd.	11/26/14	Non-Allowable		70
Foley & Lardner	12/11/14	Corporate Matters - Review Cost Reports	1,410	
Burke, Warren, MacKay & Serritella, P.C.	12/31/14	Non-Allowable		30
Williams, Montgomery & John, Ltd.	12/31/14	Non-Allowable		226
Total			10,562	12,977



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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/14Ending: 12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. N/A No
- (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?  
What was the average life used for new equipment added during this period? Yes  
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?  
If YES, give effective date of lease. No 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. \$ 198,192  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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? 100 Ln 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees

**SEE ACCOUNTANTS' COMPILATION REPORT**