

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

<p>I. IDPH License ID Number: <u>0050740</u></p> <p>Facility Name: <u>Park House Nrsg & Rehab Ctr</u></p> <p>Address: <u>2320 S Lawndale Ave</u> <u>Chicago</u> <u>60623</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 522 - 0400</u> Fax # <u>(773) 522 - 1692</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/06/09</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u> (Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u> (Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u> (Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u> (Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u>
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	5,124	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,630	49	2,886	4,565	8
9	SNF/PED					9
10	ICF	10,710	320	18,966	29,996	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,340	369	21,852	34,561	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.08%

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 1,805

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	238,905	23,833	8,271	271,009		271,009	6,931	277,940		1
2	Food Purchase		171,289		171,289		171,289	(875)	170,414		2
3	Housekeeping	190,289	33,213		223,502		223,502	799	224,301		3
4	Laundry	44,354	5,652		50,006		50,006		50,006		4
5	Heat and Other Utilities			104,161	104,161		104,161	1,104	105,265		5
6	Maintenance	50,217	4,819	171,520	226,556		226,556	8,578	235,134		6
7	Other (specify):* See Supplemental	71,508			71,508		71,508	3,468	74,976		7
8	TOTAL General Services	595,273	238,806	283,952	1,118,031		1,118,031	20,005	1,138,036		8
	B. Health Care and Programs										
9	Medical Director			23,000	23,000		23,000		23,000		9
10	Nursing and Medical Records	1,339,289	77,735	7,552	1,424,576		1,424,576	28,189	1,452,765		10
10a	Therapy	103,443			103,443		103,443		103,443		10a
11	Activities	115,972	18,117		134,089		134,089		134,089		11
12	Social Services	195,234	11,274		206,508		206,508	16,469	222,977		12
13	CNA Training										13
14	Program Transportation	819			819		819		819		14
15	Other (specify):* See Supplemental							6,184	6,184		15
16	TOTAL Health Care and Programs	1,754,757	107,126	30,552	1,892,435		1,892,435	50,842	1,943,277		16
	C. General Administration										
17	Administrative	83,579			83,579		83,579	69,177	152,756		17
18	Directors Fees										18
19	Professional Services			387,197	387,197		387,197	(298,054)	89,143		19
20	Dues, Fees, Subscriptions & Promotions			46,535	46,535		46,535	(3,651)	42,884		20
21	Clerical & General Office Expenses	164,227	7,305	241,332	412,864		412,864	(111,368)	301,496		21
22	Employee Benefits & Payroll Taxes			505,620	505,620		505,620	(9,939)	495,681		22
23	Inservice Training & Education			148	148		148		148		23
24	Travel and Seminar			125	125		125	624	749		24
25	Other Admin. Staff Transportation			4,768	4,768		4,768	727	5,495		25
26	Insurance-Prop.Liab.Malpractice			119,139	119,139		119,139	1,690	120,829		26
27	Other (specify):* See Supplemental							26,508	26,508		27
28	TOTAL General Administration	247,806	7,305	1,304,864	1,559,975		1,559,975	(324,286)	1,235,689		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,597,836	353,237	1,619,368	4,570,441		4,570,441	(253,439)	4,317,002		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security	71,508			71,508
				-
Alloc - Extended Care Consulting, LLC				-
Gen. Services - Employee Benefits			2,528	2,528
				-
Alloc. - Extended Care Clinical, LLC				-
Gen. Services - Employee Benefits			940	940
Sub-Total	<u>71,508</u>	<u>-</u>	<u>3,468</u>	<u>74,976</u>
Line 15 - Other Health Care Services				
Alloc. - Extended Care Clinical, LLC				-
Oth. Healthcare - Employee Benefits			6,184	6,184
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>6,184</u>	<u>6,184</u>
Line 27 - Other General Administration				
Alloc - Extended Care Consulting, LLC				-
Gen. Admin. - Employee Benefits			17,299	17,299
				-
Alloc. - Extended Care Clinical, LLC				-
Gen. Admin. - Employee Benefits			9,209	9,209
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>26,508</u>	<u>26,508</u>

Facility Name & ID Number

Park House Nrsg & Rehab Ctr

#0050740

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			43,948	43,948		43,948	2,184	46,132			30
31	Amortization of Pre-Op. & Org.			433	433		433		433			31
32	Interest			31,685	31,685		31,685	(11,421)	20,264			32
33	Real Estate Taxes			142,837	142,837		142,837	3,251	146,088			33
34	Rent-Facility & Grounds			344,639	344,639		344,639	(342,000)	2,639			34
35	Rent-Equipment & Vehicles			4,534	4,534		4,534	687	5,221			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			568,076	568,076		568,076	(347,299)	220,777			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,870	310,020	364,890		364,890		364,890			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,497	257,497		257,497		257,497			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers		54,870	567,517	622,387		622,387		622,387			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,597,836	408,107	2,754,961	5,760,904		5,760,904	(600,738)	5,160,166			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

**Park House Nrsg & Rehab Ctr
 Medicaid Cost Report
 01/01/16 - 12/31/16**

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total
Line 36 - Other Capital Costs							
							-
							-
							-
							-
							-
							-
							-
Sub-Total		<u>-</u>		<u>-</u>		<u>-</u>	<u>-</u>
Line 43 - Other Special Cost Centers							
							-
							-
							-
							-
							-
							-
							-
Sub-Total		<u>-</u>		<u>-</u>		<u>-</u>	<u>-</u>

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	(1,922)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,155)	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	(455)	21		18
19	Entertainment				19
20	Contributions	(750)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(194,138)	21		24
25	Fund Raising, Advertising and Promotional	(5,115)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(41,377)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (244,912)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(355,826)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (355,826)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (600,738)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	52

Park House Nrsg & Rehab Ctr

ID# 0050740

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Professional Fees - Collections	\$ (2,244)	19	1
2	Professional Fees - Lobbying	(2,233)	19	2
3	Professional Fees - Line of Credit	(1,376)	19	3
4	Professional Fees - Legal	(18,161)	19	4
5	Professional Fees - Appraisal	(2,750)	19	5
6	Bank Charges	(6,378)	21	6
7				7
8				8
9	2320 S. Lawdale, LLC			9
10	Management Fee	(1,325)	19	10
11	License	(250)	21	11
12	Bank Charges	(52)	21	12
13	State Replacement Tax	(2,409)	21	13
14	Amortization	(4,199)	31	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(41,377)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	130	0	0	0	6,801	0	0	0	0	6,931	1
2	Food Purchase	(1,155)	0	280	0	0	0	0	0	0	0	0	(875)	2
3	Housekeeping	0	0	721	0	0	78	0	0	0	0	0	799	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,005	0	0	99	0	0	0	0	0	1,104	5
6	Maintenance	0	0	2,101	6,293	0	184	0	0	0	0	0	8,578	6
7	Other (specify):*	0	0	0	2,528	0	0	940	0	0	0	0	3,468	7
8	TOTAL General Services	(1,155)	0	4,237	8,821	0	361	7,741	0	0	0	0	20,005	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	28,296	(107)	0	0	0	28,189	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	16,469	0	0	0	0	16,469	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	6,184	0	0	0	0	6,184	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	50,949	(107)	0	0	0	50,842	16
	C. General Administration													
17	Administrative	0	0	2,103	11,969	0	0	55,105	0	0	0	0	69,177	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(28,089)	1,325	(202,802)	0	0	(68,488)	0	0	0	0	0	(298,054)	19
20	Fees, Subscriptions & Promotions	(5,115)	0	682	0	0	782	0	0	0	0	0	(3,651)	20
21	Clerical & General Office Expenses	(204,432)	2,711	4,236	72,529	0	2,033	11,555	0	0	0	0	(111,368)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(9,939)	0	0	0	0	0	0	0	(9,939)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	107	0	0	517	0	0	0	0	0	624	24
25	Other Admin. Staff Transportation	0	0	727	0	0	0	0	0	0	0	0	727	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,259	0	0	431	0	0	0	0	0	1,690	26
27	Other (specify):*	0	0	0	17,299	0	0	9,209	0	0	0	0	26,508	27
28	TOTAL General Administration	(237,636)	4,036	(193,688)	91,858	0	(64,725)	75,869	0	0	0	0	(324,286)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(238,791)	4,036	(189,451)	100,679	0	(64,364)	134,559	(107)	0	0	0	(253,439)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	1,678	0	0	506	0	0	0	0	0	2,184	30
31	Amortization of Pre-Op. & Org.	(4,199)	4,199	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,922)	(15,737)	6,092	0	0	146	0	0	0	0	0	(11,421)	32
33	Real Estate Taxes	0	0	2,934	0	0	317	0	0	0	0	0	3,251	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	687	0	0	0	0	0	0	0	0	687	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,121)	(353,538)	11,391	0	0	969	0	0	0	0	0	(347,299)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(244,912)	(349,502)	(178,060)	100,679	0	(63,395)	134,559	(107)	0	0	0	(600,738)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 342,000	2320 S. Lawndale, LLC	100.00%	\$	\$ (342,000)	1
2	V	32 Interest	139,772	2320 S. Lawndale, LLC	100.00%		(139,772)	2
3	V	19 Professional Fees		2320 S. Lawndale, LLC	100.00%	1,325	1,325	3
4	V	21 Office		2320 S. Lawndale, LLC	100.00%	2,711	2,711	4
5	V	26 Property Insurance		2320 S. Lawndale, LLC	100.00%			5
6	V	30 Depreciation		2320 S. Lawndale, LLC	100.00%			6
7	V	31 Amortization		2320 S. Lawndale, LLC	100.00%	4,199	4,199	7
8	V	32 Interest		2320 S. Lawndale, LLC	100.00%	124,035	124,035	8
9	V	33 Real Estate Taxes	142,873	2320 S. Lawndale, LLC	100.00%	142,873		9
10	V	36 Mortgage Insurance Premiums		2320 S. Lawndale, LLC	100.00%			10
11	V							11
12	V							12
13	V							13
14	Total		\$ 624,645			\$ 275,143	\$ * (349,502)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending: 12/31/16

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%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Rothner Family Grandchildren Trust	10.00%	Briar Place	Indian Head, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3			Chateau Village Nursing and Rehab	Willowbrook, IL	2201 Main Street	Evanston, IL	Bldg. Company	3
4			Grasmere Place	Chicago, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Lakewood Nursing and Rehab	Plainfield, IL	Vent Lease	Evanston, IL	Vent. Rental	5
6			Lemont Nursing and Rehab	Lemont, IL	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supply	7
8			Rainbow Beach Nursing Center	Chicago, IL				8
9			Sheridan Shores	Chicago, IL				9
10			South Suburban Rehabilitation Center	Chicago, IL				10
11			Tri-State Nursing and Rehab	Lansing, IL				11
12			Wheaton Care Center	Wheaton, IL	2320 South			12
13			Kensington Place Nursing and Rehab	Chicago, IL	Lawndale, LLC	Chicago, IL	Bldg. Company	13
14			Countryside Nursing and Rehab	Dolton, IL				14
15			Spring Creek Nursing and Rehab	Joliet, IL				15
16			Park House Nursing and Rehab	Chicago, IL				16
17			Timber Point Healthcare Center	Camp Point, IL				17
18			Prairie Village Healthcare Center	Jacksonville, IL				18
19			Major Hospital - Dyer	Dyer, IN				19
20			Major Hospital - Lake County	East Chicago, IN				20
21			Major Hospital - Sebo	Holbart, IN				21
22			Major Hospital - Lincolnshire	Merrillville, IN				22
23			Major Hospital - Munster	Munster, IN				23
24			McKinley Health Care Center	Canton, OH				24
25			St. James Manor	Crete, IL				25
26			St. James Manor - Assisted Living	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29			Rushville Nursing and Rehab	Rushville, IL				29
30			Paramount of Oak Park	Oak Park, IL				30

SEE ACCOUNTANTS' PREPARATION REPORT

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Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

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12/31/16

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			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION 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%	\$ 130	\$	130	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	280		280	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	721		721	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	1,005		1,005	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	2,101		2,101	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,103		2,103	20
21	V	19 Professional Fees	207,000	Extended Care Consulting, LLC	100.00%	4,198		(202,802)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	682		682	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	4,236		4,236	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	107		107	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	727		727	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,259		1,259	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,678		1,678	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	6,092		6,092	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,934		2,934	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	687		687	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		\$ 207,000			\$ 28,940	\$ *	(178,060)	39

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

SEE ACCOUNTANTS' PREPARATION 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%	\$ 6,293	\$ 6,293	15
16	V	6 Maintenance (Direct)	12,857	Extended Care Consulting, LLC	100.00%	12,857		16
17	V	7 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	590	590	17
18	V	7 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,938	1,938	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	11,969	11,969	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	72,529	72,529	20
21	V	21 Office and Clerical (Direct)	20,272	Extended Care Consulting, LLC	100.00%	20,272		21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,455	15,455	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,844	1,844	23
24	V	22 Employee Benefits	9,939	Extended Care Consulting, LLC	100.00%		(9,939)	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		\$ 43,068			\$ 143,747	\$ * 100,679	39

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

SEE ACCOUNTANTS' PREPARATION 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	\$ 123,494	CCS VEBA	100.00%	\$ 123,494	\$	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		\$ 123,494			\$ 123,494	\$ *	39

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

SEE ACCOUNTANTS' PREPARATION 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	3 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 78	\$	78	15
16	V	5 Utilities		Extended Care Clinical, LLC	100.00%	99		99	16
17	V	6 Maintenance		Extended Care Clinical, LLC	100.00%	184		184	17
18	V	19 Professional Fees	69,000	Extended Care Clinical, LLC	100.00%	512		(68,488)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	782		782	19
20	V	21 Office and Clerical		Extended Care Clinical, LLC	100.00%	2,033		2,033	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	517		517	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	431		431	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	506		506	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	146		146	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	317		317	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		\$ 69,000			\$ 5,605	\$ *	(63,395)	39

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

SEE ACCOUNTANTS' PREPARATION 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 Clinical, LLC	100.00%	\$ 6,801	\$	6,801	15
16	V	7 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	940		940	16
17	V	10 Nursing		Extended Care Clinical, LLC	100.00%	28,296		28,296	17
18	V	12 Social Services		Extended Care Clinical, LLC	100.00%	16,469		16,469	18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,184		6,184	19
20	V	17 Administration		Extended Care Clinical, LLC	100.00%	55,105		55,105	20
21	V	21 Office		Extended Care Clinical, LLC	100.00%	11,555		11,555	21
22	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,209		9,209	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		\$			\$ 134,559	\$ *	134,559	39

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

SEE ACCOUNTANTS' PREPARATION 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	10 Nursing	\$ 1,840	Vent Lease, LLC	100.00%	\$ 1,733	\$	(107)	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		\$ 1,840			\$ 1,733	\$ *	(107)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 Supplemental	0.63	1.57%	Alloc. Salary	\$ 1,151	22 - 07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,151		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' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 2320 S. Lawndale, LLC
 Street Address 2320 S. Lawndale Avenue
 City / State / Zip Code Chicago, Illinois 60623
 Phone Number (_____) _____
 Fax Number (_____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

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Report Period Beginning:

01/01/16

Ending: 12/31/16

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	1,380,761	34	\$ 5,206	\$ 34,561	\$ 130	1
2	2	Food	Patient Days	1,380,761	34	11,203	34,561	280	2
3	3	Housekeeping	Patient Days	1,380,761	34	28,798	34,561	721	3
4	5	Utilities	Patient Days	1,380,761	34	40,168	34,561	1,005	4
5	6	Maintenance	Patient Days	1,380,761	34	83,922	34,561	2,101	5
6	17	Administrative	Patient Days	1,380,761	34	84,000	34,561	2,103	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697	34,561	4,198	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266	34,561	682	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235	34,561	4,236	9
10	24	Travel and Seminar	Patient Days	1,380,761	34	4,279	34,561	107	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053	34,561	727	11
12	26	Insurance	Patient Days	1,380,761	34	50,289	34,561	1,259	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038	34,561	1,678	13
14	32	Interest	Patient Days	1,380,761	34	243,379	34,561	6,092	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233	34,561	2,934	15
16	35	Rent - Equipment and Auto	Patient Days	1,380,761	34	27,451	34,561	687	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,156,217	\$	\$ 28,940	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending: 12/31/16

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) 941 - 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	1,380,761	34	\$ 251,431	\$ 251,431	34,561	\$ 6,293	1
2	6	Maintenance	Direct	373,682	34	373,682	373,682	12,857	12,857	2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,380,761	34	23,565		34,561	590	3
4	7	Emp. Ben. - Gen. Serv.	Direct	46,748	34	46,748		1,938	1,938	4
5	17	Administrative	Patient Days	1,380,761	34	478,172	478,172	34,561	11,969	5
6	21	Office and Clerical	Patient Days	1,380,761	34	2,897,656	2,897,656	34,561	72,529	6
7	21	Office and Clerical	Direct	460,382	34	460,382	460,382	20,272	20,272	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,380,761	34	617,434		34,561	15,455	8
9	27	Emp. Gen. - Gen. Admin.	Direct	73,413	34	73,413		1,844	1,844	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					\$ 5,222,483	\$ 4,461,323		\$ 143,747	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 Allocation	7,877,989	\$ 7,877,989	\$	123,494	\$ 123,494	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				\$ 7,877,989	\$		\$ 123,494	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending: 12/31/16

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) 941 - 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	3	Housekeeping	Patient Days	818,091	19	\$ 1,844	\$ 34,561	\$ 78	1
2	5	Utilities	Patient Days	818,091	19	2,355	34,561	99	2
3	6	Maintenance	Patient Days	818,091	19	4,352	34,561	184	3
4	19	Professional Fees	Patient Days	818,091	19	12,122	34,561	512	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512	34,561	782	5
6	21	Office and Clerical	Patient Days	818,091	19	48,124	34,561	2,033	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239	34,561	517	7
8	26	Insurance	Patient Days	818,091	19	10,196	34,561	431	8
9	30	Depreciation	Patient Days	818,091	19	11,978	34,561	506	9
10	32	Interest	Patient Days	818,091	19	3,446	34,561	146	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506	34,561	317	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					\$ 132,674	\$	\$ 5,605	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending: 12/31/16

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) 941 - 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	818,091	19	\$ 160,997	\$ 160,997	34,561	\$ 6,801	1
2	7	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		34,561	940	2
3	10	Nursing	Patient Days	818,091	19	669,803	669,803	34,561	28,296	3
4	12	Social Services	Patient Days	818,091	19	389,842	389,842	34,561	16,469	4
5	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		34,561	6,184	5
6	17	Administration	Patient Days	818,091	19	1,304,395	1,304,395	34,561	55,105	6
7	21	Office	Patient Days	818,091	19	273,525	273,525	34,561	11,555	7
8	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		34,561	9,209	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					\$ 3,185,173	\$ 2,798,562		\$ 134,559	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending: 12/31/16

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) 941 - 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	10	Nursing	Profit Margin	107,360	13	\$ 101,110	\$ 1,840	\$ 1,733	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					\$ 101,110	\$	\$ 1,733	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr # 0050740 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Chemical Bank		X	Mortgage			\$	2,721,812		\$	124,035	1								
2	Alliance Laundry Systems		X	Laundry Equipment				12,930			1,726	2								
3												3								
4												4								
5												5								
Working Capital																				
6	HFG		X	Line of Credit				1,943,931			29,959	6								
7	Alloc. - Extended Care Cons.		X	Line of Credit							6,092	7								
8	Alloc. - Extended Care Clinic		X	Line of Credit							146	8								
9	TOTAL Facility Related						\$	4,678,673		\$	161,958	9								
B. Non-Facility Related*																				
10												10								
11												11								
12	Int. Income - Operating		X								(1,922)	12								
13	Int. Income - Building		X								(139,772)	13								
14	TOTAL Non-Facility Related						\$			\$	(141,694)	14								
15	TOTALS (line 9+line14)						\$	4,678,673		\$	20,264	15								

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
 (See instructions.)

2015 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 2015 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 2015.

(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>34,496.92</u>	\$ <u>34,496.92</u>
2. <u>16 - 26 - 105 - 079 - 0000</u>	<u>Long Term Care Facility</u>	\$ <u>54,841.65</u>	\$ <u>54,841.65</u>
3. <u>16 - 26 - 105 - 080 - 0000</u>	<u>Long Term Care Facility</u>	\$ <u>54,936.21</u>	\$ <u>54,936.21</u>
4. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>167,518.13</u>	\$ <u>2,934.40</u>
5. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>36,794.68</u>	\$ <u>510.56</u>
6. <u>Alloc. - Ext. Care Clinical</u>	<u>Long Term Care Facility</u>	\$ <u>167,518.13</u>	\$ <u>317.11</u>
7. <u>Alloc. - Ext. Care Clinical</u>	<u>Long Term Care Facility</u>	\$ <u>36,794.68</u>	\$ <u>69.65</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>552,900.40</u></u>	\$ <u><u>148,106.50</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16 Ending:

12/31/16

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).

Blank lines for listing other business entities.

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Facility, Alloc. - Ext. Care, and TOTALS.

SEE ACCOUNTANTS' PREPARATION 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
	Improvement Type**										
9	Various		1989		21,943						9
10	Various		1990		11,700						10
11	Various		1991		17,413						11
12	Various		1992		55,138						12
13	Various		1993		26,399						13
14	Various		1994		3,400						14
15	Various		1995		1,500						15
16	Various		1996		106,964						16
17	Various		1997		28,175						17
18	Various		1998		114,780						18
19	Various		1999		41,539						19
20	Various		2000		7,413						20
21	Various		2001		12,564						21
22	Various		2002		13,922						22
23	Various		2003		28,642						23
24	Various		2004		10,025						24
25	Various		2005		45,846						25
26	Various		2006		40,248						26
27	Various		2007		33,310						27
28	Various		2008		25,390						28
29	Various		2009		154,704						29
30	Various		2011		13,164						30
31	Electrical Circuits with 2 Outlets		2013		3,500						31
32	Fire Dampers		2013		3,900						32
33	Hollow Metal Doors and Steel Frames		2013		5,225						33
34	Floor Drain - Sprinkler System		2013		6,650						34
35	Conduit, Relay, and Annunciator Panel		2013		2,983						35
36	Kitchen Exhaust Hood		2014		3,000						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' PREPARATION REPORT

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

Report Period Beginning:

01/01/16

Ending:

12/31/16**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	Elevator Repairs - Valves and Components	2014	\$ 9,500	\$		\$	\$	\$	37
38	Sewer Repairs - Rebuild	2014	2,800						38
39	Dumbwaiter - Doors, Cables, Switches and Chains	2014	2,322						39
40	Sewer Repairs - Rebuild	2014	2,800						40
41	Dumbwaiter - Doors, Cables, Switches and Chains	2014	5,468						41
42	Roof Repairs (Net of Insurance Proceeds)	2014	10,394						42
43	AC Unit - Mechanical Repair	2014	2,993						43
44	Elevator Repairs - Valves and Components	2014	4,200						44
45	Elevator Repairs - Valves and Components	2014	3,800						45
46	Dumbwaiter - Replace Broken Hoist Cable	2014	3,150						46
47	Roof Repairs (Net of Insurance Proceeds)	2015	5,453						47
48	Fire Pump Monitor and Controller	2015	5,813						48
49	Sprinkler Head and Tamper Install - Dumbwaiter	2015	2,687						49
50	Circuit Breaker for Emergency Systems - Electrical Panel	2015	6,300						50
51	Smoking Unit - Outside	2015	16,000						51
52	Guard Rail System and Installation	2015	4,830						52
53	Pumping System and Installation (Net of Insurance Proceeds)	2015	5,000						53
54	Fire Rated Steel Door - Laundry Room Entrance	2015	3,500						54
55	Radiant Heaters and Installation (Gas and Electric Lines)	2015	7,013						55
56	Hot Water Line Replacement and Connection to Shut Off	2015	4,000						56
57	Air Duct Fan, Heating, and Wiring	2015	4,500						57
58	Dumbwaiter Unit - Replacement - 1st Floor Basement	2015	26,500						58
59	Piping Replacement - A and B Wings	2015	3,600						59
60	Piping Replacement - A and B Wings	2015	3,843						60
61	Hot Water Heater Replacement and Installation - D Wing	2015	6,200						61
62	Sewer - Replace Pipe for Floor Controlling	2016	19,650						62
63	Baseboard Heat Cover	2016	5,805						63
64	Masonry Patching Around New Dumbwaiter	2016	2,500						64
65	Rooftop AC Unit - Remove and Replace	2016	3,994						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,233,402	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

Report Period Beginning:

01/01/16

Ending:

12/31/16**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,233,402	\$		\$	\$	\$	1
2									2
3	<u>Related Party Allocations - See Supplemental Schedules</u>								3
4									4
5	<u>Allocations - Extended Care Consulting, LLC</u>	2007	115						5
6	<u>Allocations - Extended Care Consulting, LLC</u>	2009	69						6
7	<u>Allocations - Extended Care Consulting, LLC</u>	2010	675						7
8	<u>Allocations - Extended Care Consulting, LLC</u>	2011	243						8
9	<u>Allocations - Extended Care Consulting, LLC</u>	2013	80						9
10	<u>Allocations - Extended Care Consulting, LLC</u>	2014	1,110						10
11	<u>Allocations - Extended Care Consulting, LLC</u>	2016	1,331						11
12									12
13	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	19,794						13
14	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2002	16,351						14
15	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2003	19,270						15
16	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2005	957						16
17	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2009	173						17
18	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2014	1,607						18
19	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2015	272						19
20	<u>Allocations - Extended Care Consulting, LLC / 2201 Main, LLC</u>	2016	1,076						20
21									21
22	<u>Allocations - Extended Care Consulting, LLC / Dyer Building</u>	2007	6,007						22
23									23
24	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2002	2,139						24
25	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2002	1,767						25
26	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2003	2,082						26
27	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2005	103						27
28	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2009	19						28
29	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2014	174						29
30	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2015	29						30
31	<u>Allocations - Extended Care Clinical, LLC / 2201 Main, LLC</u>	2016	116						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,308,961	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,308,961	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Depreciation - Park House Nursing & Rehabilitation Center			43,948		43,948		119,571	29
30	Depreciation - 2320 S. Lawndale, LLC							1,373,537	30
31	Depreciation - Extnded Care Consulting, LLC			1,678		1,678		129,758	31
32	Depreciation - Extended Care Clinical, LLC			506		506		7,315	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,308,961	\$ 46,132		\$ 46,132	\$	\$ 1,630,181	34

SEE ACCOUNTANTS' PREPARATION 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	\$ 107,884	\$	\$	\$		\$	71
72	Current Year Purchases	4,037						72
73	Fully Depreciated Assets							73
74	See Supplemental	282,725						74
75	TOTALS	\$ 394,646	\$	\$	\$		\$	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 Cons.			\$ 4,517	\$	\$	\$		\$	76
77	Alloc. - Ext. Care Clin.			2,170						77
78										78
79										79
80	TOTALS			\$ 6,687	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,766,860	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,132	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,132	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,630,181	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' PREPARATION REPORT

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning: 01/01/16

Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See Suppl				2,639			5
6								6
7	TOTAL				\$ 2,639			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 5,221 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION 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	\$		\$	145,920	\$		\$	145,920	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				13,335				13,335	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				142,164				142,164	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					53,732			53,732	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						1,138			1,138	12
13	Other (specify): See Supplemental	39 - 03					8,601				8,601	13
14	TOTAL			\$			310,020	\$	54,870	\$	364,890	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' PREPARATION REPORT

Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 16 Supplemental Schedule

Description	Salaries		Supplies		Other		Total
Medical Supplies			514				514
Rehab Supplies			624				624
Laboratory					5,778		5,778
Radiology					1,615		1,615
Other					1,208		1,208
							-
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							-
Total	<u>-</u>		<u>1,138</u>		<u>8,601</u>		<u>9,739</u>

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning: 01/01/16

Ending:

12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,609	\$ 324,983	1
2	Cash-Patient Deposits	22,498	22,498	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>666,557</u>)	424,402	424,402	3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,033	157,033	6
7	Other Prepaid Expenses	3,137	3,137	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	8,089	120,758	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 618,768	\$ 1,052,811	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		40,650	13
14	Buildings, at Historical Cost		1,020,720	14
15	Leasehold Improvements, at Historical Cost	198,771	351,588	15
16	Equipment, at Historical Cost	136,109	336,109	16
17	Accumulated Depreciation (book methods)	(119,571)	(1,493,108)	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>	30,612	1,011,614	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 245,921	\$ 1,267,573	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 864,689	\$ 2,320,384	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 454,019	\$ 454,019	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,790	11,790	28
29	Short-Term Notes Payable	1,943,931	1,943,931	29
30	Accrued Salaries Payable	161,235	161,235	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,376	8,376	31
32	Accrued Real Estate Taxes(Sch.IX-B)		151,489	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	166,550		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,745,901	\$ 2,730,840	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	12,930	12,930	39
40	Mortgage Payable		2,721,812	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,930	\$ 2,734,742	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,758,831	\$ 5,465,582	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,894,142)	\$ (3,145,198)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 864,689	\$ 2,320,384	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Security Deposit	1,580		1,580
Due from Others	2,723		2,723
Settlements - Third Party Payers	3,786		3,786
Accrued Interest Income		48,833	48,833
Escrow - Real Estate Taxes		63,836	63,836
Sub-Total	<u>8,089</u>	<u>112,669</u>	<u>120,758</u>
Line 23 - Long Term Assets			
Due from Affiliated Entities	28,349	972,955	1,001,304
Financing Fees (Net of Amortization)	1,793	8,047	9,840
State Replacement Tax Benefit	470		470
			-
			-
Sub-Total	<u>30,612</u>	<u>981,002</u>	<u>1,011,614</u>
Line 36 - Other Current Liability			
Due to 2320 S. Lawndale, LLC	166,550	(166,550)	-
			-
			-
			-
			-
Sub-Total	<u>166,550</u>	<u>(166,550)</u>	<u>-</u>
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,408,470)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,408,469)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(485,673)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (485,673)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,894,142)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,184,551	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,184,551	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,710	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 88,710	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	48	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,922	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,922	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,275,231	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,118,031	31
32	Health Care	1,892,435	32
33	General Administration	1,559,975	33
B. Capital Expense			
34	Ownership	568,076	34
C. Ancillary Expense			
35	Special Cost Centers	364,890	35
36	Provider Participation Fee	257,497	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,760,904	40
41	Income before Income Taxes (line 30 minus line 40)**	(485,673)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (485,673)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,096,617	44
45	Private Pay - Net Inpatient Revenue	57,405	45
46	Medicare - Net Inpatient Revenue	944,481	46
47	Other-(specify) <u>Insurance - Net Patient Revenue</u>	46,630	47
48	Other-(specify) <u>Hospice - Net Patient Revenue</u>	39,418	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,184,551	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' PREPARATION REPORT

Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 19 Supplemental Schedule

Description		Amount		Total
N/A				-
				-
				-
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		-		
Total		-		-

Facility Name & ID Number Park House Nrsg & Rehab Ctr

0050740

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,898	2,144	\$ 78,764	\$ 36.74	1
2	Assistant Director of Nursing	1,885	2,211	70,300	31.80	2
3	Registered Nurses	3,296	3,496	94,285	26.97	3
4	Licensed Practical Nurses	14,598	16,060	425,533	26.50	4
5	CNAs & Orderlies	42,385	47,716	550,926	11.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,472	6,222	103,443	16.63	8
9	Activity Director	1,777	1,974	32,948	16.69	9
10	Activity Assistants	7,136	7,988	83,024	10.39	10
11	Social Service Workers	10,386	11,092	195,234	17.60	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,161	49,598	22.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,562	17,421	189,307	10.87	15
16	Dishwashers					16
17	Maintenance Workers	2,435	2,684	50,217	18.71	17
18	Housekeepers	15,516	17,248	190,289	11.03	18
19	Laundry	3,584	4,091	44,354	10.84	19
20	Administrator	2,106	2,220	83,579	37.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,503	10,633	164,227	15.45	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	1,936	2,098	33,526	15.98	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	9,287	9,991	158,282	15.84	33
34	TOTAL (lines 1 - 33)	150,602	167,450	\$ 2,597,836 *	\$ 15.51	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	\$ 8,271	01 - 03	35
36	Medical Director	23,000	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,552	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			44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>See Supplemental Schedule</u>			47
48				48
49	TOTAL (lines 35 - 48)	\$ 38,823		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' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Laura Feliciano - Dixon	Administrator	0	\$ 6,679	Workers' Compensation Insurance	\$ 73,289	IDPH License Fee	\$ 1,990		
Amy Skrypkun - Castro	Administrator	0	76,900	Unemployment Compensation Insurance	50,260	Advertising: Employee Recruitment	21,204		
				FICA Taxes	202,124	Health Care Worker Background Check (Indicate # of checks performed)	2,226		
				Employee Health Insurance	157,577	<u>Patient Background Checks</u>			
				Employee Meals		<u>Dues - ICLTC</u>	11,595		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues and Subscriptions</u>	2,297		
				Other Employee Benefits	22,370	<u>Licenses and Fees</u>	2,108		
				<u>Page 6B - Employee Benefit Offset</u>	(9,939)	<u>Advertising and Promotion</u>	5,115		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,579			<u>Alloc. - Ext. Care Cons. / Clinical</u>	1,464		
B. Administrative - Other						Less: Public Relations Expense	()		
Description			Amount			Non-allowable advertising	(5,115)		
			\$			Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 495,681	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 42,884
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Extended Care Consulting	Management Fee		\$ 207,000				Out-of-State Travel	\$	
Extended Care Clinical	Management Fee		69,000						
Plante & Moran, PLLC	Accounting		13,175				In-State Travel		
Personnel Planners, Inc.	Unemployment Consultant		1,536						
Matrix Care	Data Processing / IT		33,050				Seminar Expense	125	
National Datacare Corporation	Data Processing / IT		2,669				Alloc. - Extended Care Consulting	107	
Ability Network	Data Processing / IT		1,896				Alloc. - Extended Care Clinical	517	
Propay Payroll Services	Data Processing / IT		18,522						
Other Miscellaneous Vendors	Data Processing / IT		900				Entertainment Expense	()	
Holly Turner, Esq	Legal		2,706				(agree to Sch. V, line 24, col. 8)		
Arnstein Lehr, LLP	Legal		4,788				TOTAL	\$ 749	
See Supplemental Schedule			31,955						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 387,197	TOTAL		\$			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Park House Nrsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	01/31/16	30	30	-
Holly Turner, Esq	Non-Allowable	02/25/16	238	238	-
Williams Montgomery & John, Ltd	Non-Allowable	02/25/16	694	694	-
Holly Turner, Esq	Non-Allowable	03/25/16	238	238	-
Williams Montgomery & John, Ltd	Non-Allowable	03/25/16	1,292	1,292	-
Huston, May & Faye, LLC	Corporate / Compliance Matters	03/31/16	811	473	338
Holly Turner, Esq	Non-Allowable	04/20/16	238	238	-
Arnstein & Lehr, LLP	Corporate / Compliance Matters	05/20/16	1,836	-	1,836
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	05/22/16	44	44	-
Holly Turner, Esq	Non-Allowable	05/26/16	238	238	-
Huston, May & Faye, LLC	Corporate / Compliance Matters	05/26/16	1,655	647	1,008
Williams Montgomery & John, Ltd	Non-Allowable	05/26/16	2,451	2,451	-
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	06/29/16	13	13	-
Holly Turner, Esq	Non-Allowable	06/29/16	238	238	-
Williams Montgomery & John, Ltd	Non-Allowable	06/29/16	461	461	-
Williams Montgomery & John, Ltd	Non-Allowable	07/29/16	1,791	1,791	-
Arnstein & Lehr, LLP	Corporate / Compliance Matters	07/31/16	2,520	-	2,520
Holly Turner, Esq	Non-Allowable	08/19/16	238	238	-
Williams Montgomery & John, Ltd	Non-Allowable	08/19/16	1,168	1,168	-
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	08/23/16	9	9	-
Arnstein & Lehr, LLP	Corporate / Compliance Matters	08/24/16	432	-	432
Williams Montgomery & John, Ltd	Non-Allowable	08/31/16	83	83	-
Holly Turner, Esq	Non-Allowable	08/31/16	296	296	-
Falkenberg, Fieweger Ives, LLP	Non-Allowable	09/30/16	765	765	-
Huston, May & Faye, LLC	Non-Allowable	10/31/16	2,909	2,909	-
Holly Turner, Esq	Non-Allowable	11/30/16	238	238	-
Falkenberg, Fieweger Ives, LLP	Non-Allowable	11/30/16	1,560	1,560	-
Huston, May & Faye, LLC	Corporate / Compliance Matters	11/30/16	4,895	-	4,895
Burke, Warren, Mackay & Serritella, PC	Non-Allowable	12/31/16	35	35	-
Holly Turner, Esq	Non-Allowable	12/31/16	743	743	-
Falkenberg, Fieweger Ives, LLP	Non-Allowable	12/31/16	1,030	1,030	-
					-
Total			29,189	18,161	11,028

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

Report Period Beginning:

01/01/16Ending: 12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$11,595
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,088 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 257,497
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. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
d. Have vehicle usage logs been maintained? 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' PREPARATION REPORT