

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0050740</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Park House Nursing & Rehab Center, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>2320 South Lawndale Avenue</u> <u>Chicago</u> <u>60623</u> Number City Zip Code																																																			
County: <u>Cook</u>																																																			
Telephone Number: <u>(773) 522 - 0400</u> Fax # <u>(773) 522 - 1692</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>12/16/09</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																																																	
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust					☐	Other _____			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>	
☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																														
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		☐	Trust																																																
		☐	Other _____																																																
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: _____		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Park House Nursing & Rehab Center, LLC

#

0050740

Report Period Beginning:

01/01/11

Ending:

12/31/11

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		2,146	2,780	4,926	8
9	SNF/PED					9
10	ICF	30,291			30,291	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,291	2,146	2,780	35,217	14

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

91.02%

SEE ACCOUNTANTS' COMPILATION REPORT

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

126

(Do not include bed-hold days in Section B.)

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

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

YES

X

Date

NO

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

YES

X

NO

If YES, enter number of beds certified

14

and days of care provided

2,780

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

12/31/11

Fiscal Year:

12/31/11

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

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	204,843	17,956	7,777	230,576		230,576	183	230,759			1
2	Food Purchase		177,615		177,615		177,615	(1,398)	176,217			2
3	Housekeeping	116,299	22,207		138,506		138,506	372	138,878			3
4	Laundry	46,324	13,843		60,167		60,167	(320)	59,847			4
5	Heat and Other Utilities			91,150	91,150		91,150	652	91,802			5
6	Maintenance	70,063		91,912	161,975		161,975	6,827	168,802			6
7	Other (specify):* Supplemental	75,051			75,051		75,051	889	75,940			7
8	TOTAL General Services	512,580	231,621	190,839	935,040		935,040	7,205	942,245			8
	B. Health Care and Programs											
9	Medical Director			37,800	37,800		37,800		37,800			9
10	Nursing and Medical Records	1,189,312	64,372	6,160	1,259,844		1,259,844	(598)	1,259,246			10
10a	Therapy	80,995			80,995		80,995		80,995			10a
11	Activities	68,950	11,269	2,496	82,715		82,715		82,715			11
12	Social Services	293,076	29,240	700	323,016		323,016		323,016			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,632,333	104,881	47,156	1,784,370		1,784,370	(598)	1,783,772			16
	C. General Administration											
17	Administrative	217,933			217,933		217,933	8,615	226,548			17
18	Directors Fees											18
19	Professional Services			252,519	252,519		252,519	(140,319)	112,200			19
20	Dues, Fees, Subscriptions & Promotions			30,146	30,146		30,146	(12,504)	17,642			20
21	Clerical & General Office Expenses	52,099	18,872	319,886	390,857		390,857	(230,026)	160,831			21
22	Employee Benefits & Payroll Taxes			447,388	447,388		447,388	(3,696)	443,692			22
23	Inservice Training & Education			1,598	1,598		1,598		1,598			23
24	Travel and Seminar			4,530	4,530		4,530	121	4,651			24
25	Other Admin. Staff Transportation			12,835	12,835		12,835	308	13,143			25
26	Insurance-Prop.Liab.Malpractice			76,903	76,903		76,903	583	77,486			26
27	Other (specify):* Supplemental							14,077	14,077			27
28	TOTAL General Administration	270,032	18,872	1,145,805	1,434,709		1,434,709	(362,841)	1,071,868			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,414,945	355,374	1,383,800	4,154,119		4,154,119	(356,234)	3,797,885			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.

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	75,051		
Allocation - Extended Care Consulting: Emp. Ben.			889
Total	75,051	-	889
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Allocation - Extended Care Consulting: Emp. Ben.			14,077
Total	-	-	14,077

Park House Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Payee	Amount	Allowable
Care Consultants of Illinois	4,194	4,194
Countryside Nursing Reimbursement	3,369	3,369
Fleet Services	724	724
Lorena Robledo-Sommerfield	1,260	1,260
Melissa Houser	3,233	3,233
Nyekya Williams	21	21
Sheryl Schreiber	13	13
Stephanie White	21	21
Alloc. - Extended Care Consulting	308	308

13,143

13,143

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			2,192	2,192		2,192	55,751	57,943			30
31	Amortization of Pre-Op. & Org.			2,700	2,700		2,700		2,700			31
32	Interest			4,199	4,199		4,199	(4,199)				32
33	Real Estate Taxes							135,889	135,889			33
34	Rent-Facility & Grounds			13,572	13,572		13,572	(13,572)				34
35	Rent-Equipment & Vehicles			21,199	21,199		21,199	2,386	23,585			35
36	Other (specify):*											36
37	TOTAL Ownership			43,862	43,862		43,862	176,255	220,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,619	270,103	416,722		416,722	(83,882)	332,840			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,583	200,583		200,583		200,583			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		146,619	470,686	617,305		617,305	(83,882)	533,423			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,414,945	501,993	1,898,348	4,815,286		4,815,286	(263,861)	4,551,425			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(9,554)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,574)	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	(9,101)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(277,716)	21		24
25	Fund Raising, Advertising and Promotional	(14,693)	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 See Supplemental	(68,142)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (380,780)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	116,919		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 116,919		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (263,861)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (3,511)	21	1
2	Bank Charges	(16,049)	21	2
3	Collection Fees	(71)	21	3
4	Other Expenses	(15)	21	4
5	TAG Properties - Office Space	(13,572)	34	5
6	Non-Allowable Other Professional	(1,620)	19	6
7	Non-Allowable Legal	(28,355)	19	7
8				8
9	2320 South Lawndale, LLC			9
10	Loan Fees	(3,500)	21	10
11	State Replacement Tax	(1,449)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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	(68,142)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park House Nursing & Rehab Center, LLC# 0050740

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	183	0	0	0	0	0	0	0	0	183	1
2	Food Purchase	(1,574)	0	176	0	0	0	0	0	0	0	0	(1,398)	2
3	Housekeeping	0	0	372	0	0	0	0	0	0	0	0	372	3
4	Laundry	0	0	0	0	(320)	0	0	0	0	0	0	(320)	4
5	Heat and Other Utilities	0	0	652	0	0	0	0	0	0	0	0	652	5
6	Maintenance	0	0	1,872	4,955	0	0	0	0	0	0	0	6,827	6
7	Other (specify):*	0	0	0	889	0	0	0	0	0	0	0	889	7
8	TOTAL General Services	(1,574)	0	3,255	5,844	(320)	0	0	0	0	0	0	7,205	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	(598)	0	0	0	0	0	0	(598)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	(598)	0	0	0	0	0	0	(598)	16
	C. General Administration													
17	Administrative	0	0	1,956	6,659	0	0	0	0	0	0	0	8,615	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(29,975)	0	(110,344)	0	0	0	0	0	0	0	0	(140,319)	19
20	Fees, Subscriptions & Promotions	(14,693)	0	2,189	0	0	0	0	0	0	0	0	(12,504)	20
21	Clerical & General Office Expenses	(311,412)	4,949	8,110	68,327	0	0	0	0	0	0	0	(230,026)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(3,696)	0	0	0	0	0	0	0	(3,696)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	121	0	0	0	0	0	0	0	0	121	24
25	Other Admin. Staff Transportation	0	0	308	0	0	0	0	0	0	0	0	308	25
26	Insurance-Prop.Liab.Malpractice	0	0	583	0	0	0	0	0	0	0	0	583	26
27	Other (specify):*	0	0	0	14,077	0	0	0	0	0	0	0	14,077	27
28	TOTAL General Administration	(356,080)	4,949	(97,077)	85,367	0	0	0	0	0	0	0	(362,841)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(357,654)	4,949	(93,822)	91,211	(918)	0	0	0	0	0	0	(356,234)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	49,455	6,296	0	0	0	0	0	0	0	0	55,751	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,554)	0	5,355	0	0	0	0	0	0	0	0	(4,199)	32
33	Real Estate Taxes	0	134,924	965	0	0	0	0	0	0	0	0	135,889	33
34	Rent-Facility & Grounds	(13,572)	0	0	0	0	0	0	0	0	0	0	(13,572)	34
35	Rent-Equipment & Vehicles	0	0	2,386	0	0	0	0	0	0	0	0	2,386	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,126)	184,379	15,002	0	0	0	0	0	0	0	0	176,255	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	(131)	0	(83,751)	0	0	0	0	(83,882)	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	(131)	0	(83,751)	0	0	0	0	(83,882)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(380,780)	189,328	(78,820)	91,211	(1,049)	0	(83,751)	0	0	0	0	(263,861)	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	\$	2320 South Lawndale, LLC	100.00%	\$	\$	1
2	V	21	State Replacement Tax		2320 South Lawndale, LLC	100.00%	1,449	1,449	2
3	V	21	Loan Fees		2320 South Lawndale, LLC	100.00%	3,500	3,500	3
4	V	30	Depreciation		2320 South Lawndale, LLC	100.00%	49,455	49,455	4
5	V	31	Amortization		2320 South Lawndale, LLC	100.00%			5
6	V	32	Interest		2320 South Lawndale, LLC	100.00%			6
7	V	33	Real Estate Taxes		2320 South Lawndale, LLC	100.00%	134,924	134,924	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 189,328	\$ * 189,328	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Park House Nursing & Rehab Center, LLC

0050740

Report Period Beginning:

01/01/11

Ending:

12/31/11

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 183	\$ 183	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	176	176	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	372	372	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	652	652	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,872	1,872	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,956	1,956	20
21	V	19	Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	3,656	(110,344)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,189	2,189	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	8,110	8,110	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	121	121	24
25	V	25	Other Staff Admin. Transport.		Extended Care Consulting, LLC	100.00%	308	308	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	583	583	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	6,296	6,296	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	5,355	5,355	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	965	965	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	2,386	2,386	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 114,000			\$ 35,180	\$ * (78,820)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	\$	Extended Care Consulting, LLC	100.00%	\$ 4,955	\$ 4,955	15
16	V	06	Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%	889	889	17
18	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%			18
19	V	17	Administrative		Extended Care Consulting, LLC	100.00%	6,659	6,659	19
20	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	68,071	68,071	20
21	V	21	Office and Clerical	10,169	Extended Care Consulting, LLC	100.00%	10,425	256	21
22	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	12,858	12,858	22
23	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	1,219	1,219	23
24	V	22	Employee Benefits	3,696	Extended Care Consulting, LLC	100.00%		(3,696)	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			\$ 13,865			\$ 105,076	\$ * 91,211	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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	03	Housekeeping		Xcel Supply, LLC	100.00%			16
17	V	04	Laundry	5,270	Xcel Supply, LLC	100.00%	4,950	(320)	17
18	V	06	Repairs and Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	9,862	Xcel Supply, LLC	100.00%	9,264	(598)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office and Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	2,165	Xcel Supply, LLC	100.00%	2,034	(131)	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			\$ 17,297			\$ 16,248	\$ * (1,049)	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.

☒ X

 YES

☐ NO

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

1		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	Health Insurance	\$ 32,091	CCS VEBA	100.00%	\$ 32,091	\$	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			\$ 32,091			\$ 32,091	\$ *	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.

☒ X

 YES

☐

 NO

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

1		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	Therapy	\$ 265,986	Tricare Rehab	100.00%	\$ 182,235	\$ (83,751)	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			\$ 265,986			\$ 182,235	\$ * (83,751)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		See Attached	0.19	0.00	Alloc. Sal	\$ 339	22 - 7	1
2	G. Matt Silvers	Relative	Administrative		See Attached	0.06	0.00	Alloc. Sal	217	17 - 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 556		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,332,501	31	\$ 6,942	\$	35,217	\$ 183	1
2	02	Food	Patient Days	1,332,501	31	6,677		35,217	176	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		35,217	372	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		35,217	652	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		35,217	1,872	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		35,217	1,956	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		35,217	3,656	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		35,217	2,189	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		35,217	8,110	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		35,217	121	10
11	25	Other Staff Admin. Transpor.	Patient Days	1,332,501	31	11,637		35,217	308	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		35,217	583	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		35,217	6,296	13
14	32	Interest	Patient Days	1,332,501	31	202,602		35,217	5,355	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		35,217	965	15
16	35	Rent - Equipment and Auto	Patient Days	1,332,501	31	90,286		35,217	2,386	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,331,098	\$		\$ 35,180	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Patient Days	1,332,501	31	\$ 187,474	\$ 187,474	35,217	\$ 4,955	1
2	06	Maintenance	Direct Allocation	1	1			1		2
3	07	Employee Benefits	Patient Days	1,332,501	31	33,619		35,217	889	3
4	07	Employee Benefits	Direct Allocation	1	1			1		4
5	17	Administrative	Patient Days	1,332,501	31	251,959	251,959	35,217	6,659	5
6	21	Office and Clerical	Patient Days	1,332,501	31	2,575,611	2,575,611	35,217	68,071	6
7	21	Office and Clerical	Direct Allocation	1	1	10,425	10,425	1	10,425	7
8	27	Employee Benefits	Patient Days	1,332,501	31	486,522		35,217	12,858	8
9	27	Employee Benefits	Direct Allocation	1	1	1,219		1	1,219	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					\$ 3,546,829	\$ 3,025,469		\$ 105,076	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Xcel Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 328 - 7600
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation	1	1	\$	\$	1	\$	1
2	03	Housekeeping	Direct Allocation	1	1			1		2
3	04	Laundry	Direct Allocation	1	1	4,950		1	4,950	3
4	06	Repairs and Maintenance	Direct Allocation	1	1			1		4
5	10	Nursing	Direct Allocation	1	1	9,264		1	9,264	5
6	11	Activities	Direct Allocation	1	1			1		6
7	21	Office and Clerical	Direct Allocation	1	1			1		7
8	22	Employee Benefits	Direct Allocation	1	1			1		8
9	30	Depreciation	Direct Allocation	1	1			1		9
10	39	Ancillary	Direct Allocation	1	1	2,034		1	2,034	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					\$ 16,248	\$		\$ 16,248	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Health Insurance	Direct Allocation	1	1	\$ 32,091	\$	1	\$ 32,091	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					\$ 32,091	\$		\$ 32,091	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC # 0050740 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation	1	1	\$ 182,235	\$	1	\$ 182,235	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					\$ 182,235	\$		\$ 182,235	25

SEE ACCOUNTANTS' COMPILATION REPORT

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							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Extended Care Consulting	X		Line of Credit							5,355	6
7	HFG	X		Line of Credit							4,199	7
8												8
9	TOTAL Facility Related						\$				\$ 9,554	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,554)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (9,554)	14
15	TOTALS (line 9+line14)						\$				\$	15

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

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

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 report.		\$	130,063		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	130,227		2
3. Under or (over) accrual (line 2 minus line 1).		\$	164		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	135,725		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	135,889		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	72,265	8		
	2007	71,493	9		
	2008	72,211	10		
	2009	123,870	11		
	2010	129,262	12		
2011 Tax Accrual = \$129,262 * 1.05 = \$135,725					
Extended Care Consulting, LLC (Allocation) - \$965					
The opening Real Estate Tax Accrual was revised from last year's balance of \$88,458 based on post adjustments.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park House Nursing & Rehab Center, LLC COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0050740
CONTACT PERSON REGARDING THIS REPORT Edward N. Slack
TELEPHONE (847) 628 - 8796 FAX #: (847) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(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>37,188.86</u>	\$ <u>37,188.86</u>
2.	<u>16-26-105-079-0000</u>	<u>Long Term Care Facility</u>	\$ <u>45,994.64</u>	\$ <u>45,994.64</u>
3.	<u>16-26-105-080-0000</u>	<u>Long Term Care Facility</u>	\$ <u>46,078.62</u>	\$ <u>46,078.62</u>
4.	<u>Allocation</u>	<u>Extended Care Consulting, LLC</u>	\$ <u>126,481.18</u>	\$ <u>1,347.66</u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>255,743.30</u></u>	\$ <u><u>130,609.78</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:

26,849

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories
- C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 40,650	1
2	Ext. Care Consult.			8,737	2
3	TOTALS			\$ 49,387	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park House Nursing & Rehab Center, LLC# 0050740

Report Period Beginning:

01/01/11

Ending:

12/31/11**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	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	Heat and Sump Pump			2008	14,059						28
29	Pipe and Sewer Line - Replace			2008	8,100						29
30	Wire Door to Alarm			2008	3,231						30
31	Bathroom Showers, Tubs, Sinks, Toilets and Tile			2009	128,320						31
32	Spinkler Heads			2009	4,375						32
33	Roof Repair			2009	2,300						33
34	Electrical Work			2009	4,500						34
35	Carpet and Flooring			2009	8,300						35
36	Water Heater and Roof Exhaust			2009	6,909						36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Six Delay Egress Doors	2011	\$ 8,534	\$ 213	20	\$ 213	\$	\$ 213	37
38 Two Temperature Control Compressors - Installation	2011	4,630	232	5	232		232	38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 814,179	\$ 445		\$ 445	\$	\$ 445	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		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		\$ 814,179	\$ 445		\$ 445	\$	\$ 445	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	2320 South Lawndale, LLC - Building	1989	1,209,350	43,976	27.5	43,976		1,009,624	5
6									6
7	Allocations - Extended Care Consulting	2007	122	6		6		30	7
8	Allocations - Extended Care Consulting	2009	73	4		4		11	8
9	Allocations - Extended Care Consulting	2010	713	36		36		71	9
10	Allocations - Extended Care Consulting	2011	257	13		13		13	10
11									11
12	Allocations - Extended Care Consulting / 2201 Main LLC	2002	12,040	309		309		2,869	12
13	Allocations - Extended Care Consulting / 2201 Main LLC	2002	9,946	909		909		7,280	13
14	Allocations - Extended Care Consulting / 2201 Main LLC	2003	11,721	1,071		1,071		8,580	14
15	Allocations - Extended Care Consulting / 2201 Main LLC	2005	582	62		62		334	15
16	Allocations - Extended Care Consulting / 2201 Main LLC	2009	105	5		5		16	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,059,088	\$ 46,836		\$ 46,836	\$	\$ 1,029,273	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	\$	\$	\$	\$	5 - 7	\$	71
72	Current Year Purchases	16,817	1,746	1,746		5 - 7	1,746	72
73	Fully Depreciated Assets							73
74	See Supplemental	469,035	9,228	9,228		5	418,926	74
75	TOTALS	\$ 485,852	\$ 10,974	\$ 10,974	\$		\$ 420,672	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	Extended Care Consulting			\$ 8,499	\$ 133	\$ 133	\$	5	\$ 8,366	76
77										77
78										78
79										79
80	TOTALS			\$ 8,499	\$ 133	\$ 133	\$		\$ 8,366	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)	\$ 2,602,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 57,943	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,943	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)	\$ 1,458,311	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.

Park House Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - 2320 South Lawndale, LLC			
Prior	359,746	5,479	314,816
Current			
Total	359,746	5,479	314,816
Related Party 2 - Extended Care Consulting			
Prior	77,558	265	75,675
Current	86	9	9
Total	77,644	274	75,684
Related Party 3 - Extended Care Consulting / 2201 Mail LLC			
Prior	3,334	333	2,962
Current			
Total	3,334	333	2,962
Related Party 4 - Extended Care Consulting - Matrix Software			
Prior	28,311	3,142	25,464
Current			
Total	28,311	3,142	25,464
Total	469,035	9,228	418,926

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								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☐ NO Terms: *

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: \$ 19,365 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Various	\$	\$ 4,220	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,220	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2012 | \$ |
| 13. | /2013 | \$ |
| 14. | /2014 | \$ |

* 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
Medicaid Cost Report
01/01/11 - 12/31/11

Page 14 Supplemental Schedule - Building Rental

Vendor	Description	Amount
TAG Properties	Office Space	13,572
TAG Properties	Office Space - Non Allowable	(13,572)
Total		-

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Description	Amount
GE Capital	Copier	8,757
Hughes Enterprises	Medical Equipment	8,220
Care Consultants of Illinois	Various	2
Alloc. - Extended Care Consulting		2,386
Total		19,365

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

- (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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 141,272	\$		\$ 141,272	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,422			1,422	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			123,262			123,262	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				125,751		125,751	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					20,868		20,868	12
13	Other (specify): See Supplemental	39 - 03				4,147			4,147	13
14	TOTAL			\$		\$ 270,103	\$ 146,619		\$ 416,722	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

Page 16 Supplemental Schedule

IL478-2471

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	\$	\$ 1,233	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 222,930)	1,642,820	1,642,820	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,576	53,576	6
7	Other Prepaid Expenses	17,784	17,784	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	321,201	361,015	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,035,381	\$ 2,076,428	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		1,209,350	14
15	Leasehold Improvements, at Historical Cost	13,164	172,910	15
16	Equipment, at Historical Cost	16,817	216,817	16
17	Accumulated Depreciation (book methods)	(2,192)	(1,326,624)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 27,789	\$ 313,103	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,063,170	\$ 2,389,531	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,103,256	\$ 1,103,256	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,711	23,711	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,371	97,371	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		135,725	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	701	701	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,225,039	\$ 1,360,764	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,467,039	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,467,039	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,225,039	\$ 3,827,803	46
47	TOTAL EQUITY(page 18, line 24)	\$ 838,131	\$ (1,438,272)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,063,170	\$ 2,389,531	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 94,385	1
2	Restatements (describe):		2
3	Post Cost Report Accounting Adjustments	(13,665)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 80,720	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	757,411	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)	\$ 757,411	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)	\$ 838,131	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Park House Nursing & Rehab Center, LLC**# **0050740**Report Period Beginning: **01/01/11**Ending: **12/31/11****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,508,395	1
2	Discounts and Allowances for all Levels	(1,163,221)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,345,174	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,081,516	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,081,516	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	120,752	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,063	20
21	Other Medical Services	2,427	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126,242	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,254	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,254	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,511	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,511	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,572,697	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	935,040	31
32	Health Care	1,784,370	32
33	General Administration	1,434,709	33
	B. Capital Expense		
34	Ownership	43,862	34
	C. Ancillary Expense		
35	Special Cost Centers	416,722	35
36	Provider Participation Fee	200,583	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,815,286	40
41	Income before Income Taxes (line 30 minus line 40)**	757,411	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 757,411	43

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

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

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

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

Park House Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Other Income	3,511	3,511
Total	3,511	3,511

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	1,935	2,092	\$ 88,288	\$ 42.20	1
2	Assistant Director of Nursing	1,983	2,743	81,589	29.74	2
3	Registered Nurses	5,535	5,918	159,475	26.95	3
4	Licensed Practical Nurses	14,106	15,410	378,983	24.59	4
5	CNAs & Orderlies	39,048	43,924	454,519	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,736	4,412	80,995	18.36	8
9	Activity Director	1,938	2,126	26,746	12.58	9
10	Activity Assistants	4,330	4,664	42,204	9.05	10
11	Social Service Workers	14,682	16,316	293,076	17.96	11
12	Dietician					12
13	Food Service Supervisor	1,967	2,168	44,619	20.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,393	5,024	52,316	10.41	15
16	Dishwashers	9,536	10,842	107,908	9.95	16
17	Maintenance Workers	3,996	4,339	70,063	16.15	17
18	Housekeepers	11,560	12,894	116,299	9.02	18
19	Laundry	4,017	4,616	46,324	10.04	19
20	Administrator	1,919	2,121	89,664	42.27	20
21	Assistant Administrator					21
22	Other Administrative	4,421	4,547	128,269	28.21	22
23	Office Manager					23
24	Clerical	2,097	2,337	52,099	22.29	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	1,975	2,141	26,458	12.36	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Supplemental</u>	8,033	8,563	75,051	8.76	33
34	TOTAL (lines 1 - 33)	141,207	157,197	\$ 2,414,945 *	\$ 15.36	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	137	\$ 7,777	01 - 03	35
36	Medical Director	Monthly	37,800	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,160	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	48	2,496	11 - 03	44
45	Social Service Consultant	12	700	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	197	\$ 54,933		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

Park House Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Security	8,033	8,563	75,051
Total	8,033	8,563	75,051

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	
Melissa Lindsay	Administrator	0	\$ 89,664	Workers' Compensation Insurance	\$ 75,507	IDPH License Fee	\$ 1,990	
Lorena Robledo-Sommerfield	Executive	0	64,914	Unemployment Compensation Insurance	76,319	Advertising: Employee Recruitment	938	
Laura Sepessy	Executive	0	43,678	FICA Taxes	189,050	Health Care Worker Background Check	8,696	
Lasonda Wilkins - Hines	Executive	0	19,677	Employee Health Insurance	78,902	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	560	
				Employee Physicals	144	Licenses and Fees	3,269	
TOTAL (agree to Schedule V, line 17, col. 1)				Holiday Expense	1,900	Advertising and Promotion	14,693	
(List each licensed administrator separately.)			\$ 217,933	Pension	17,542	Alloc. - Extended Care Consulting	2,189	
B. Administrative - Other				Chicago Employer Tax	2,912			
Description			Amount	Other Employee Welfare	1,416	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	(14,693)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 443,692	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,642	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount				\$	Out-of-State Travel	\$
Extended Care Consulting	Home Office	\$ 114,000						
Personnel Planners	Unemployment Consultant	2,783						
Frost, Ruttenberg & Rothblatt	Accounting	7,357						
Plante & Moran, PLLC	Accounting	9,900					In-State Travel	
Krupnic, Bokar & Kagda	Accounting	3,964						
Denise Carnes	Bookkeeping	1,205						
Elderlife Development	Code Compliance	0						
Blymas, Inc.	Accounting	661					Seminar Expense	4,530
Judy Burnell	Bookkeeping	488					Alloc. - Extended Care Consulting	121
Ron Cournaya	Medicare Cost Report	1,250						
Jared Starr	Medicare Cost Report	1,250						
See Supplemental Schedule		109,661					Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 252,519				TOTAL	\$ 4,651

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Park House Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Chad Cournaya	Other Professional	184
Faces Photography	Other Professional	
Hamlin & Burton Liability	MSP Services	155
TAG Properties	Non-Allowable	1,620
Comcast Cable	Computer Maintenance	900
Care Consultants of Illinois	Computer Maintenance	17,284
OmniCare of Northern Illinois	Computer Maintenance	740
Care Consultants of Illinois	Other Professional	93
American Data	Data Processing	4,152
MDI Achieve	Data Processing	20,301
E Health Data Solutions	Data Processing	5,950
Medifax	Data Processing	291
Care Consultants of Illinois	Data Processing	437
Extended Care Consulting	Data Processing	5,755
Nebo Systems	Data Processing	86
National Datacare Corporation	Data Processing	2,809
Paycor	Data Processing	7,791
Melissa Houser	Data Processing	52
Ashman & Stein	Legal	843
K & L Gates	Legal	5,461
Chuhak & Tecson, P.C.	Legal	6,510
Deutsch, Levy & Engel	Legal	10,025
Statland Law Offices, LLC	Legal	277
Hamlin & Burton	Legal	350
Law Office Of Stephen N.	Legal	2,076
HFG	Legal	2,162
Mcvey & Parsky, Llc	Legal	1,000
Meyer Magence	Legal	12,356
		109,661

Park House Nursing & Rehab Center, LLC
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Page 21 Supplemental Schedule - Legal Schedule

Vendor	Invoice Date	Amount	Allowable
Chuhak & Tecson, P.C.	01/31/11	756	
Chuhak & Tecson, P.C.	02/28/11	340	
Law Office Of Stephen N.	02/28/11	674	
Law Office Of Stephen N.	02/28/11	1,080	
Law Office Of Stephen N.	02/28/11	321	
Meyer Magence	02/28/11	2,470	2,470
Meyer Magence	02/28/11	1,207	1,207
Hamilin & Burton	03/22/11	350	350
Chuhak & Tecson, P.C.	03/31/11	108	
Meyer Magence	03/31/11	1,022	1,022
Meyer Magence	03/31/11	375	375
Chuhak & Tecson, P.C.	04/30/11	72	
HFG	04/30/11	82	
Meyer Magence	04/30/11	1,269	1,269
Chuhak & Tecson, P.C.	05/31/11	180	
HFG	05/31/11	2,080	
Chuhak & Tecson, P.C.	06/30/11	902	
Meyer Magence	06/30/11	1,732	1,732
Meyer Magence	06/30/11	1,038	1,038
Chuhak & Tecson, P.C.	08/31/11	432	
Chuhak & Tecson, P.C.	08/31/11	160	
Ashman & Stein	09/30/11	152	
K & L Gates	09/30/11	816	
K & L Gates	09/30/11	1,003	
Chuhak & Tecson, P.C.	09/30/11	72	
Chuhak & Tecson, P.C.	09/30/11	36	
Meyer Magence	09/30/11	250	250
Meyer Magence	09/30/11	2,163	2,163
Ashman & Stein	10/31/11	336	
Ashman & Stein	10/31/11	355	
Chuhak & Tecson, P.C.	10/31/11	5	
Chuhak & Tecson, P.C.	10/31/11	46	
Chuhak & Tecson, P.C.	10/31/11	324	
Mcvey & Parsky, Llc	11/15/11	1,000	
K & L Gates	12/31/11	3,642	
Chuhak & Tecson, P.C.	12/31/11	72	
Chuhak & Tecson, P.C.	12/31/11	142	
Chuhak & Tecson, P.C.	12/31/11	62	
Chuhak & Tecson, P.C.	12/31/11	10	
Chuhak & Tecson, P.C.	12/31/11	474	
Chuhak & Tecson, P.C.	12/31/11	130	
Chuhak & Tecson, P.C.	12/31/11	288	
Chuhak & Tecson, P.C.	12/31/11	565	
Chuhak & Tecson, P.C.	12/31/11	10	
Chuhak & Tecson, P.C.	12/31/11	441	
Deutsch, Levy & Engel	12/31/11	5,778	
Deutsch, Levy & Engel	12/31/11	1,148	
Deutsch, Levy & Engel	12/31/11	1,455	
Deutsch, Levy & Engel	12/31/11	866	
Deutsch, Levy & Engel	12/31/11	779	
Statland Law Offices, LLC	12/31/11	277	
Meyer Magence	12/31/11	707	707
Meyer Magence	12/31/11	125	125
Chuhak & Tecson, P.C.	12/31/11	292	
Chuhak & Tecson, P.C.	12/31/11	137	
Chuhak & Tecson, P.C.	12/31/11	50	
Chuhak & Tecson, P.C.	12/31/11	14	
Chuhak & Tecson, P.C.	12/31/11	344	
Chuhak & Tecson, P.C.	12/31/11	43	

41,061	12,706
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Page 5 Adjustment

28,355

Park House Nursing & Rehab Center, LLC
Medicaid Cost Report
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Page 21 Supplemental Schedule - Seminar Schedule

Payee	Topic	Attendee	Location	Amount
Care Consultants of Illinois	HIN Seminars			677
ICLTC	Writing Winning IDRs & Other Hot Topic Frontline legal Issues	J. Patrick/M. Houser/L. Sepessy	Skokie, IL	495
ICLTC	The New Medicaid Integrated Care Program	M. Houser/L. Sepessy/E. Moncada	Oak Lawn, IL	315
Melissa Houser	Merchant IL Council on Long Term Care-Seminar 2927B	Sherwin Ray	Oak Lawn, IL	165
Certified Food Safety	Sanitation License Course	Daisy Wilson	Chicago, IL	195
Pathway Health Services	ICD-Coding		Westmont, IL	169
Care Consultants of Illinois	HIN Seminar			66
ICLTC	Recent Changes in Advance Directives	M. Hauser/L. Sepessy/J. Patrick/C. Wilson	Oak Lawn, IL	660
ICLTC	Recent Changes in Advance Directives	L. Wilkins-Hines	Oak Lawn, IL	165
Pathway Health Services	Restorative/Rehab Certification Pgm for Licensed Nurses	Cowanda Wilson	Westmont, IL	749
Care Consultants of Illinois	HIN Seminar (SNF PPS Update)	L. Sepessy	Bloomingtondale, IL	179
Care Consultants of Illinois	IL Healthcare Assoc (SNF PPS Final Rule & Other Medicare Challenge	L. Sepessy	Lisle, IL	200
ICLTC	No Contact, No Drug Behavior De-escalation	M. Lindsay/H. Dropski/L. Sepessy	Oak Lawn, IL	495
Alloc. - Extended Care Consulting				121

4,651

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Park House Nursing & Rehab Center, LLC		STATE OF ILLINOIS	#	0050740	Report Period Beginning:	01/01/11	Ending:	12/31/11	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?					Yes					
(2)	Are there any dues to nursing home associations included on the cost report?					No					
	If YES, give association name and amount.					N/A					
(3)	Did the nursing home make political contributions or payments to a political action organization?					No	If YES, have these costs been properly adjusted out of the cost report?				
						N/A					
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?					No	If YES, what is the capacity?				
						N/A					
(5)	Have you properly capitalized all major repairs and equipment purchases?					Yes					
	What was the average life used for new equipment added during this period?					10 Years					
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$		1,151	Line		10		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?					Yes	If NO, attach a complete explanation.				
(8)	Are you presently operating under a sale and leaseback arrangement?					No					
	If YES, give effective date of lease.					N/A					
(9)	Are you presently operating under a sublease agreement?			YES		X	NO				
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES			NO		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.			\$		200,583	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?		Indicate the amount. \$		
						No			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. \$				
	c. What percent of all travel expense relates to transportation of nurses and patients?					N/A	Ln 14				
	d. Have vehicle usage logs been maintained?					No					
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?					No					
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?					Yes					
	g. Does the facility transport residents to and from day training?					No	Indicate the amount of income earned from providing such transportation during this reporting period. \$				
						N/A					
(17)	Has an audit been performed by an independent certified public accounting firm?					No	Firm Name:				
						N/A					
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?					Yes					
(19)	If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?					Yes	Attach invoices and a summary of services for all architect and appraisal fees				

SEE ACCOUNTANTS' COMPILATION REPORT