FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0052159

Facility Name: Heights Hlthcare & Rehab Ctr

Address: 1629 Gardner Lane (Number) Peoria Heights (City) 61614 (Zip Code)

County: Peoria

Telephone Number: (309) 685-1545 **Fax #** (309) 685-1571

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2013

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 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.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,710		2,365	20,075	8
9	SNF/PED					9
10	ICF	11,456	725		12,181	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,166	725	2,365	32,256	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.34%

D. How many bed-hold days during this year were paid by the Department?
None (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 01/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 1,487

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	275,707	40,697	8,241	324,645		324,645	13	324,658			1
2	Food Purchase		210,347		210,347		210,347	(47)	210,300			2
3	Housekeeping	121,945	31,385		153,330		153,330	787	154,117			3
4	Laundry	80,810	8,724	198	89,732		89,732		89,732			4
5	Heat and Other Utilities			89,781	89,781		89,781	(9,435)	80,346			5
6	Maintenance	58,082	13,082	43,852	115,016		115,016	13,660	128,676			6
7	Other (specify):*											7
8	**TOTAL General Services**	536,544	304,235	142,072	982,851		982,851	4,978	987,829			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600	8,902	30,502			9
10	Nursing and Medical Records	1,697,496	78,062	88,694	1,864,252		1,864,252	37,586	1,901,838			10
10a	Therapy	89,259		11,581	100,840		100,840		100,840			10a
11	Activities	94,039	9,321	1,660	105,020		105,020		105,020			11
12	Social Services	195,941		10,208	206,149		206,149	1,078	207,227			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,531	6,531			15
16	**TOTAL Health Care and Programs**	2,076,735	87,383	133,743	2,297,861		2,297,861	54,098	2,351,959			16
	C. General Administration											
17	Administrative	96,922		72,106	169,028		169,028	(7,929)	161,099			17
18	Directors Fees											18
19	Professional Services			180,628	180,628	(101)	180,527	(106,278)	74,248			19
20	Dues, Fees, Subscriptions & Promotions			46,897	46,897		46,897	(4,671)	42,226			20
21	Clerical & General Office Expenses	198,788	17,985	191,108	407,881		407,881	(105,115)	302,766			21
22	Employee Benefits & Payroll Taxes			412,165	412,165		412,165		412,165			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,141	2,141		2,141	81	2,222			24
25	Other Admin. Staff Transportation			23,861	23,861		23,861	1,005	24,866			25
26	Insurance-Prop.Liab.Malpractice			51,230	51,230		51,230	409	51,639			26
27	Other (specify):*							22,397	22,397			27
28	**TOTAL General Administration**	295,710	17,985	980,136	1,293,831	(101)	1,293,730	(200,101)	1,093,628			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,908,989	409,603	1,255,951	4,574,543	(101)	4,574,442	(141,025)	4,433,416			29

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

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr #0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,118	21,118		21,118	190,983	212,101			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,406	39,406		39,406	327,231	366,637			32
33	Real Estate Taxes			54,081	54,081	101	54,182	1,706	55,888			33
34	Rent-Facility & Grounds			441,958	441,958		441,958	(441,958)	0			34
35	Rent-Equipment & Vehicles			24,829	24,829		24,829	(10,887)	13,942			35
36	Other (specify):*							(0)	(0)			36
37	**TOTAL Ownership**			581,392	581,392	101	581,493	67,076	648,569			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,974	241,694	300,668		300,668		300,668			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,659	246,659		246,659		246,659			42
43	Other (specify):*			7,094	7,094		7,094	(7,094)	0			43
44	**TOTAL Special Cost Centers**		58,974	495,447	554,421		554,421	(7,094)	547,327			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,908,989	468,577	2,332,790	5,710,356		5,710,356	(81,043)	5,629,313			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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(10,701)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(72,499)	30		9
10	Interest and Other Investment Income	(1,482)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(90)	21		18
19	Entertainment	(748)	21		19
20	Contributions	(225)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(138,884)	21		24
25	Fund Raising, Advertising and Promotional	(11,669)	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	(50,887)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (287,232)		$	30

BHF USE ONLY								
48		49		50		51		52

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)	206,189		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 206,189		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (81,043)		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

STATE OF ILLINOIS **Page 5A**

Heights Hlthcare & Rehab Ctr

ID# 0052159

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (193)	21	1
2	Marketing Consultant	(7,062)	43	2
3	Bank Charges	(4,016)	21	3
4	Theft and Loss	(18)	21	4
5	Additional R&M	10,637	06	5
6	Non-allowable Auto Lease	(13,166)	35	6
7	Building Company - Accounting Fees	(1,268)	19	7
8	Building Company - Amortization	(27,549)	36	8
9	COPE Dues	(1,728)	20	9
10	Non-allowable Seminar	(300)	24	10
11	Marketing	(32)	43	11
12	Non-allowable Legal	(1,590)	19	12
13	Sequester	(4,603)	21	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**	(50,887)		49

Heights Hlthcare & Rehab Ctr

ID# 0052159

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 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			13									13	1
2	Food Purchase	(47)											(47)	2
3	Housekeeping			787									787	3
4	Laundry													4
5	Heat and Other Utilities	(10,701)		954		312							(9,435)	5
6	Maintenance	10,637		2,452		571							13,660	6
7	Other (specify):*													7
8	**TOTAL General Services**	(111)		4,206		883							4,978	8
	B. Health Care and Programs													
9	Medical Director			8,902									8,902	9
10	Nursing and Medical Records			37,586									37,586	10
10a	Therapy													10a
11	Activities													11
12	Social Services			1,078									1,078	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,531									6,531	15
16	**TOTAL Health Care and Programs**			54,098									54,098	16
	C. General Administration													
17	Administrative			23,447	(31,376)								(7,929)	17
18	Directors Fees													18
19	Professional Services	(2,857)	1,268	(105,190)	100	401							(106,278)	19
20	Fees, Subscriptions & Promotions	(13,622)		8,884		66							(4,671)	20
21	Clerical & General Office Expenses	(148,552)	(47,886)	91,286	17	20							(105,115)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(300)		381									81	24
25	Other Admin. Staff Transportation			1,004	2								1,005	25
26	Insurance-Prop.Liab.Malpractice			256		153							409	26
27	Other (specify):*			18,677	3,720								22,397	27
28	**TOTAL General Administration**	(165,331)	(46,618)	38,745	(27,538)	640							(200,101)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(165,442)	(46,618)	97,049	(27,538)	1,524							(141,025)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(72,499)	255,198	6,420		1,864							190,983	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,482)	325,240	23		3,450							327,231	32
33	Real Estate Taxes					1,706							1,706	33
34	Rent-Facility & Grounds		(441,958)	10,087		(10,087)							(441,958)	34
35	Rent-Equipment & Vehicles	(13,166)		106	2,173								(10,887)	35
36	Other (specify):*	(27,549)	27,549										(0)	36
37	**TOTAL Ownership**	(114,696)	166,029	16,636	2,173	(3,066)							67,076	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(7,094)											(7,094)	43
44	**TOTAL Special Cost Centers**	(7,094)											(7,094)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(287,232)	119,411	113,685	(25,365)	(1,543)							(81,043)	45

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 441,958	THHRC Realty LLC	100.00%	$	$ (441,958)	1
2	V	19	Accounting Fees		THHRC Realty LLC	100.00%	1,268	1,268	2
3	V	21	Other Income	47,886	THHRC Realty LLC	100.00%		(47,886)	3
4	V	36	Amortization Expense		THHRC Realty LLC	100.00%	27,549	27,549	4
5	V	30	Depreciation Expense		THHRC Realty LLC	100.00%	255,198	255,198	5
6	V	32	Interest Expense		THHRC Realty LLC	100.00%	325,240	325,240	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 489,844			$ 609,255	$ * 119,411	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	MANAGCARE, INC.	100.00%	$ 13	$ 13	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	787	787	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	954	954	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,452	2,452	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	8,902	8,902	19
20	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	37,586	37,586	20
21	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	1,078	1,078	21
22	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	6,531	6,531	22
23	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	23,447	23,447	23
24	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	848	848	24
25	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	8,884	8,884	25
26	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	68,698	68,698	26
27	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	22,588	22,588	27
28	V	24	SEMINARS		MANAGCARE, INC.	100.00%	381	381	28
29	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	1,004	1,004	29
30	V	26	INSURANCE		MANAGCARE, INC.	100.00%	256	256	30
31	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	18,677	18,677	31
32	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	6,420	6,420	32
33	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	23	23	33
34	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	10,087	10,087	34
35	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	106	106	35
36	V								36
37	V	19	BOOKKEEPING/COMP SERV	106,038	MANAGCARE, INC.	100.00%		(106,038)	37
38	V								38
39	Total			$ 106,038			$ 219,723	$ * 113,685	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE SALARY - NATH	$	TETRAD MANAGEMENT, LLC	100.00%	$ 12,639	$ 12,639	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	4,344	4,344	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	12,639	12,639	17
18	V	17	ADMINISTRATIVE FEES - YOSEF DAVIS		TETRAD MANAGEMENT, LLC	100.00%	11,108	11,108	18
19	V								19
20	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	100	100	20
21	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	17	17	21
22	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2	2	22
23	V	27	EMPLOYEE BEENFITS- PAYROLL TAXES		TETRAD MANAGEMENT, LLC	100.00%	3,720	3,720	23
24	V	35	AUTO LEASE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	2,173	2,173	24
25	V								25
26	V								26
27	V								27
28	V	17	MANAGEMENT FEES	72,106	TETRAD MANAGEMENT, LLC	100.00%		(72,106)	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			$ 72,106			$ 46,741	$ * (25,365)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	4600 TOUHY, LLC	100.00%	$ 312	$ 312	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	571	571	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	401	401	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	66	66	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	20	20	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	153	153	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,864	1,864	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	3,450	3,450	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	1,706	1,706	23
24	V								24
25	V	34	RENT	10,087	4600 TOUHY, LLC	100.00%		(10,087)	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			$ 10,087			$ 8,544	$ * (1,543)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	EVAN MICHAEL STERN 2005 TRUST	0.50%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	THHRC REALTY, LLC	LINCOLNWOOD	BUILDING COMPANY	1
2	ILANA AARON	1.00%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	2
3	JONATHAN BRYAN STERN 2001 TRUST	0.50%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	3
4	ABRAHAM J. STERN	3.00%	CAPITOL HEALTHCARE & REHABILITATION CTR., LLC	SPRINGFIELD	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	4
5	AHARON SHKOP	1.43%	COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON				5
6	ARISTA HOLDINGS GROUP LLC	4.76%	THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS				6
7	BASSMAN FAMILY LP	4.76%	MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				7
8	CENTRAL IL YD DELTA	61.90%	MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				8
9	CENTRAL IL YD DELTA	0.05%	RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				9
10	DIAMOND INVESTMENT GROUP LLC	4.76%	MAYFIELD HEALTHCARE AND REHAB CENTER	CHICAGO				10
11	EFRAIM M. LEVIN	1.00%						11
12	EMMA AARON	1.00%						12
13	LARRY MANDEL	0.95%						13
14	PERL GROUP LLC	1.43%						14
15	ROSEN FAMILY INVESTMENTS LLC	1.43%						15
16	TEED EQUITY HOLDINGS LLC	9.52%						16
17	TODD A. STERN	2.00%						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' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Relative	Mgmt /Admin		See Attached	1.19	3.97%	Alloc. Fees	$ 11,108	17-7	1
2	Moshe Davis	Relative	Mgmt /Admin		See Attached	2.92	6.64%	Alloc. Salary	12,639	17-7	2
3	Yehoshua Davis	Relative	Mgmt /Admin		See Attached	3.19	6.65%	Alloc. Salary	4,344	17-7	3
4	Nesanel Davis	Relative	Mgmt /Admin		See Attached	3.19	6.65%	Alloc. Salary	12,639	17-7	4
5	Eli Davis	Relative	Mgmt /Admin		See Attached	2.65	6.63%	Alloc. Fees	465	17-7	5
6	Archie Shkop	Shareholder	Administrative	1.43%	See Attached	2.99	6.64%	Alloc. Salary	9,205	17-7	6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 50,400		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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MANAGCARE, INC.
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	DIETARY	PATIENT DAYS	486,626	10	$ 198	$	32,294	$ 13	1
2	3	HOUSEKEEPING	PATIENT DAYS	486,626	10	11,856		32,294	787	2
3	5	UTILITIES	PATIENT DAYS	486,626	10	14,381		32,294	954	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	486,626	10	36,948		32,294	2,452	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	486,626	10	134,142		32,294	8,902	5
6	10	NURSING SALARIES	PATIENT DAYS	486,626	10	566,366	566,366	32,294	37,586	6
7	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	486,626	10	16,247	16,247	32,294	1,078	7
8	15	NURSING EMP BENS & PR TA	PATIENT DAYS	486,626	10	98,421		32,294	6,531	8
9	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	486,626	10	353,309	353,309	32,294	23,447	9
10	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	12,785		32,294	848	10
11	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	486,626	10	133,874		32,294	8,884	11
12	21	CLERICAL AND GENERAL SA	PATIENT DAYS	486,626	10	1,035,183	1,035,183	32,294	68,698	12
13	21	CLERICAL AND GENERAL EX	PATIENT DAYS	486,626	10	340,374		32,294	22,588	13
14	24	SEMINARS	PATIENT DAYS	486,626	10	5,737		32,294	381	14
15	25	ADMIN. STAFF TRANS.	PATIENT DAYS	486,626	10	15,128		32,294	1,004	15
16	26	INSURANCE	PATIENT DAYS	486,626	10	3,851		32,294	256	16
17	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	486,626	10	281,440		32,294	18,677	17
18	30	DEPRECIATION	PATIENT DAYS	486,626	10	96,741		32,294	6,420	18
19	32	INTEREST EXPENSE	PATIENT DAYS	486,626	10	346		32,294	23	19
20	34	RENT - BUILDING (RELATED)	PATIENT DAYS	486,626	10	152,000		32,294	10,087	20
21	35	EQUIPMENT RENTAL	PATIENT DAYS	486,626	10	1,597		32,294	106	21
22										22
23										23
24										24
25	TOTALS					$ 3,310,923	$ 1,971,105		$ 219,723	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: TETRAD MANAGEMENT, LLC
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	$ 190,457	$ 190,457	32,294	$ 12,639	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	65,457	65,457	32,294	4,344	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	190,457	190,457	32,294	12,639	3
4	17	ADMINISTRATIVE FEES - YO	PATIENT DAYS	486,626	10	167,375		32,294	11,108	4
5	17	TOTAL MANAGEMENT FEES	PATIENT DAYS	486,626	10			32,294		5
6	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	1,500		32,294	100	6
7	21	OFFICE EXPENSE	PATIENT DAYS	486,626	10	253		32,294	17	7
8	25	TRAVEL	PATIENT DAYS	486,626	10	23		32,294	2	8
9	27	EMPLOYEE BEENFITS- PAYF	PATIENT DAYS	486,626	10	56,057		32,294	3,720	9
10	35	AUTO LEASE EXPENSE	PATIENT DAYS	486,626	10	32,750		32,294	2,173	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					$ 704,328	$ 446,371		$ 46,741	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 4600 TOUHY, LLC
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((773) 463-1313
Fax Number: ((773) 463- 5311

	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	5	UTILITIES	MNGCR. PATIENT DAYS	486,626	10	$ 4,702	$	32,294	$ 312	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	486,626	10	8,610		32,294	571	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	486,626	10	6,043		32,294	401	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	486,626	10	1,001		32,294	66	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	486,626	10	300		32,294	20	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	486,626	10	2,308		32,294	153	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	486,626	10	28,092		32,294	1,864	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	486,626	10	51,990		32,294	3,450	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	486,626	10	25,708		32,294	1,706	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					$ 128,752	$		$ 8,544	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage			$	$ 4,311,377			$ 243,054	1
2	Greystone		X	Mortgage				538,922			82,186	2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				1,084,767		5.2500	39,362	6
7	Allocated from Managcare		X								23	7
8	See Supplemental Schedule										3,450	8
9	TOTAL Facility Related						$	$ 5,935,066			$ 368,074	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,482)	10
11	Interest Expense		X								44	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,438)	14
15	TOTALS (line 9+line14)						$	$ 5,935,066			$ 366,637	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from 4600 Touhy		X				$	$			$ 3,450	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,450	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 53,020	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.)		$ 54,726	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,706	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,081	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.)**		$ 101	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.		$ 55,889	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	52,012	8
	2009		9
	2010	51,362	10
	2011	52,350	11
	2012	53,020	12

2013 Accrual = $53,020 x 1.02 = $54,081

Allocated from 4600 Touhy = $1,706

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heights Hlthcare & Rehab Ctr COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052159

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	Long Term Care Property	$ 53,020.26	$ 53,020.26
2.	See Attached	Alloc. From 4600 Touhy	$ 48,715.81	$ 1,616.47
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,736.07	$ 54,636.73

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heights Hlthcare & Rehab Ctr COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052159

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior Cement Block Frame Metal Beam Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	400,860	2013	$ 290,419	1
2					2
3	TOTALS	400,860		$ 290,419	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	110		2013	1977	$ 2,273,994	$ 255,198	35	$ 64,971	$ (190,227)	$ 58,457	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		69,045	2,954		2,885	(69)	5,473	68
69	Financial Statement Depreciation			21,118			(21,118)		69
70	TOTAL (lines 4 thru 69)		$ 2,343,039	$ 279,270		$ 67,856	$ (211,414)	$ 63,930	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,343,039	$ 279,270		$ 67,856	$ (211,414)	$ 63,930	1
2	Mop Sink Faucet And Valve	2013	4,119		20	229	229	229	2
3	Window Treatments	2013	63,058		20	3,153	3,153	3,153	3
4	Design Services For Building Renovation Project	2013	13,000		20	650	650	650	4
5	Installed New Circuit Control Board And Power Supply	2013	5,545		20	555	555	555	5
6	Installed 20 Light Fixtures In Corridors, 8 In Therapy Room, 23 Ir	2013	26,062		20	2,606	2,606	2,606	6
7	Installed 12 New Drop Sinks And Level Faucets In New Laminate	2013	8,271		20	827	827	827	7
8	Demolition, Dumping And Removal Of Carpet And Vinyl Flooring	2013	44,365		20	4,437	4,437	4,437	8
9	Installed Vinyl Plank Flooring In Corridor, Dining, Nurse Station,	2013	77,993		20	7,799	7,799	7,799	9
10	Installed New Drywall At New Therapy Room, Installed New Doub	2013	17,680		20	1,768	1,768	1,768	10
11	Installed 12 New Corian Vanity Top With Drop Sink, Installed 36 I	2013	50,656		20	5,066	5,066	5,066	11
12	Paint Drywall Ceilings, Acoustical Ceilings, 50 Doors And Frames,	2013	25,772		20	2,577	2,577	2,577	12
13	Installed 4 Additional Sprinklers To Each Side Of The Existing Sp	2013	7,292		20	729	729	729	13
14	Additional Electrical, Plumbing, & Flooring For Resident Rooms, I	2013	29,712		20	2,971	2,971	2,971	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,716,564	$ 279,270		$ 101,223	$ (178,047)	$ 97,297	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,716,564	$ 279,270		$ 101,223	$ (178,047)	$ 97,297	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,716,564	$ 279,270		$ 101,223	$ (178,047)	$ 97,297	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,716,564	$ 279,270		$ 101,223	$ (178,047)	$ 97,297	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,716,564	$ 279,270		$ 101,223	$ (178,047)	$ 97,297	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,716,564	$ 279,270		$ 101,223	$ (178,047)	$ 97,297	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
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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)		$ 2,716,564	$ 279,270		$ 101,223	$ (178,047)	$ 97,297	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy	2012	34,075	874	20	1,136	262	2,272	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare	2012	7,114	763	20	356	(407)	711	9
10	Allocated from Managcare	2013	572	326	20	29	(297)	29	10
11									11
12	Allocated from 4600 Touhy	2012	21,944	574	20	1,097	523	2,194	12
13	Allocated from 4600 Touhy	2013	5,340	417	20	267	(150)	267	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued		$	$		$	$	$	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 69,045	$ 2,954		$ 2,885	$ (69)	$ 5,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 13,748	$ 1,547	$ 1,375	$ (172)	10	$ 3,080	71
72	Current Year Purchases	1,142,038	3,286	108,587	105,301	10	108,588	72
73	Fully Depreciated Assets	16,345		7	7	10	16,345	73
74								74
75	TOTALS	$ 1,172,131	$ 4,833	$ 109,969	$ 105,136		$ 128,013	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		Allocated from Managcare	2013	$ 8,020	$ 498	$ 910	$ 412	5	$ 6,424	76
77										77
78										78
79										79
80	TOTALS			$ 8,020	$ 498	$ 910	$ 412		$ 6,424	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)	$ 4,187,134	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 284,601	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,102	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (72,499)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 231,733	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	Construction Management	$ 9,107	92
93			93
94			94
95		$ 9,107	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] 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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 11,769 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Tetrad		$	$ 2,173	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,173	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
   - [X] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$		$ 90,888	$		$ 90,888	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			15,169			15,169	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			113,672			113,672	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 prescrpts				49,462		49,462	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					21,965	9,512		31,477	13
14	TOTAL			$		$ 241,694	$ 58,974		$ 300,668	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

STATE OF ILLINOIS

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 132,427	$ 159,372	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	917,882	917,882	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,015	74,015	6
7	Other Prepaid Expenses	81,723	81,723	7
8	Accounts Receivable (owners or related parties)	136,443	136,443	8
9	Other(specify): See Attached Schedule	32,756	32,756	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,375,246	$ 1,402,191	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		290,419	13
14	Buildings, at Historical Cost		2,273,994	14
15	Leasehold Improvements, at Historical Cost	297,467	297,467	15
16	Equipment, at Historical Cost	274,858	1,223,463	16
17	Accumulated Depreciation (book methods)	(21,118)	(276,317)	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 Attached Schedule	9,107	2,463,315	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 560,314	$ 6,272,341	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,935,560	$ 7,674,532	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 588,796	$ 588,793	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,276	18,276	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,134	128,134	30
31	Accrued Taxes Payable (excluding real estate taxes)	77,156	77,156	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,081	54,081	32
33	Accrued Interest Payable	1,896	2,555	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	117,088	998,767	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 985,427	$ 1,867,762	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,084,767	1,084,767	39
40	Mortgage Payable		4,850,299	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)**	$ 1,084,767	$ 5,935,066	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,070,194	$ 7,802,828	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (134,634)	$ (128,296)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,935,560	$ 7,674,532	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(134,634)	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)**	$ (134,634)	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)**	$ (134,634)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,973,433	1
2	Discounts and Allowances for all Levels	(893,762)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,079,671	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	432,926	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 432,926	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	52,419	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,930	19
20	Radiology and X-Ray	1,597	20
21	Other Medical Services	4,504	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 61,450	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,482	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,482	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	193	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 193	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,575,722	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	982,851	31
32	Health Care	2,297,861	32
33	General Administration	1,293,831	33
	B. Capital Expense		
34	Ownership	581,392	34
	C. Ancillary Expense		
35	Special Cost Centers	307,762	35
36	Provider Participation Fee	246,659	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,710,356	40
41	**Income before Income Taxes (line 30 minus line 40)****	(134,634)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (134,634)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,408,165	44
45	Private Pay - Net Inpatient Revenue	151,298	45
46	Medicare - Net Inpatient Revenue	413,222	46
47	Other-(specify) Hospice	106,986	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,079,671	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,908	2,032	$ 67,054	$ 33.00	1
2	Assistant Director of Nursing	1,400	1,472	43,963	29.87	2
3	Registered Nurses	10,924	11,462	328,719	28.68	3
4	Licensed Practical Nurses	21,888	23,180	571,036	24.63	4
5	CNAs & Orderlies	51,723	54,591	676,761	12.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,965	5,488	89,259	16.26	8
9	Activity Director	2,077	2,134	35,094	16.45	9
10	Activity Assistants	5,400	5,592	58,945	10.54	10
11	Social Service Workers	9,314	9,928	195,941	19.74	11
12	Dietician					12
13	Food Service Supervisor	2,178	2,306	38,883	16.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,798	22,968	236,824	10.31	15
16	Dishwashers					16
17	Maintenance Workers	3,688	4,017	58,082	14.46	17
18	Housekeepers	11,328	11,894	121,945	10.25	18
19	Laundry	6,627	7,024	80,810	11.50	19
20	Administrator	1,556	1,695	82,699	48.79	20
21	Assistant Administrator	480	520	14,223	27.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,932	13,686	198,788	14.52	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	638	653	9,963	15.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,824	180,642	$ 2,908,989 *	$ 16.10	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	145	$ 8,241	01-03	35
36	Medical Director	Monthly	21,600	09-03	36
37	Medical Records Consultant	Quarterly	2,080	10-03	37
38	Nurse Consultant	Monthly	67,125	10-03	38
39	Pharmacist Consultant	Monthly	6,289	10-03	39
40	Physical Therapy Consultant	Visit	65	10a-03	40
41	Occupational Therapy Consultant	Monthly	11,516	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,660	11-03	44
45	Social Service Consultant	157	10,208	12-03	45
46	Other(specify)				46
47					47
48	MDS Consultant	Monthly	13,200	10 - 03	48
49	TOTAL (lines 35 - 48)	328	$ 141,984		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rebecca Rohrs	Assistant Admin.	0	$ 14,223
Lorene Foust (Term. 2/8/13)	Administrator	0	18,502
Clinton McDaniel (4/29 - 08/30)	Administrator	0	37,745
Linda Stiltz (9/1 - 11/10)	Administrator	0	14,221
Rebecca Newble (Start 11/11/13)	Administrator	0	12,231
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,922

B. Administrative - Other

Description	Amount
Management Fees - Tetrad	$ 72,106
TOTAL (agree to Schedule V, line 17, col. 3)	$ 72,106
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Doris Clink	Operational Consulting	$ 750
Madison Specs	Property Engineering	2,439
Zimmet Healthcare Services	Healthcare Consulting	778
Templin Healthcare Accounting	Healthcare Consulting	519
Prospect Resources	Natural Procurement	752
ProviNET	IT Consulting	701
Rue Ann Mills	Corporate Consultant	1,917
Ability Network, Inc.	Billing Software	774
American Data	Electronic Charting System	2,942
eHealth Data Solutions	MDS Software	1,652
Galaxy Hosted Software	Clinical & Financial Software	12,079
See Supplemental Schedule		155,324
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 180,627

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,365
Unemployment Compensation Insurance	92,688
FICA Taxes	211,343
Employee Health Insurance	28,254
Employee Meals	631
Illinois Municipal Retirement Fund (IMRF)*	
Dental	684
Vision	44
Employee Benefits	10,591
Pension	5,643
Holiday Expense	2,923
TOTAL (agree to Schedule V, line 22, col.8)	$ 412,166

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,906
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 882	8,821
License and Permits	2,798
Dues and Subscriptions	15,750
Allocated from Managcare	8,884
Allocated from 4600 Touhy	66
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,224

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,841
Allocated from Managcare	381
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,222

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Heights Hlthcare & Rehab Ctr # 0052159 Report Period Beginning: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC 5,235**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,171** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **246,659**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **631** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.