

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

<p>I. IDPH License ID Number: <u>0023945</u></p> <p>Facility Name: <u>Heather Health Care Center</u></p> <p>Address: <u>15600 S Honore St</u> <u>Harvey</u> <u>60426</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 333-9550</u> Fax # <u>(708) 333-9554</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/01/81</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773)286-3883</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2014</u> to <u>12/31/2014</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Steve Kroll</u> (Title) <u>Chief Financial Officer, Alden Management Services as agent</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Steve Kroll</u> (Title) <u>Chief Financial Officer, Alden Management Services as agent</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Steve Kroll</u> (Title) <u>Chief Financial Officer, Alden Management Services as agent</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Heather Health Care Center

0023945 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	13	Skilled (SNF)	173	63,145	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less		0	6
7	13	TOTALS	173	63,145	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,840	80	1,690	5,610	8
9	SNF/PED					9
10	ICF	39,733	63	1,009	40,805	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,573	143	2,699	46,415	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.51%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 4/1/1978

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 173 and days of care provided 1,684

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	230,145	29,982	25,800	285,927	1,551	287,478	(10,633)	276,845		1
2	Food Purchase		353,486		353,486	(30,888)	322,598	(32,543)	290,055		2
3	Housekeeping	212,225	40,742		252,967	1,390	254,357	8,661	263,018		3
4	Laundry	66,580	24,713		91,293	365	91,658		91,658		4
5	Heat and Other Utilities			165,306	165,306		165,306	(1,519)	163,787		5
6	Maintenance	60,793		169,505	230,298	188	230,486	17,432	247,918		6
7	Other (specify):* related party/security			192	192		192	8,965	9,157		7
8	TOTAL General Services	569,743	448,923	360,803	1,379,469	(27,394)	1,352,075	(9,637)	1,342,438		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,906,566	112,069	8,294	2,026,929	9,791	2,036,720	45,658	2,082,378		10
10a	Therapy		2,344	24,844	27,188		27,188		27,188		10a
11	Activities	333,676	15,243	1,305	350,224	41	350,265		350,265		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							7,577	7,577		15
16	TOTAL Health Care and Programs	2,240,242	129,656	52,443	2,422,341	9,832	2,432,173	53,235	2,485,408		16
	C. General Administration										
17	Administrative	101,276			101,276		101,276	121,563	222,839		17
18	Directors Fees										18
19	Professional Services			410,838	410,838		410,838	(348,289)	62,549		19
20	Dues, Fees, Subscriptions & Promotions			31,219	31,219		31,219	(15,529)	15,690		20
21	Clerical & General Office Expenses	85,870	15,090	104,727	205,687	664	206,351	297,537	503,888		21
22	Employee Benefits & Payroll Taxes			586,616	586,616	15,475	602,091		602,091		22
23	Inservice Training & Education										23
24	Travel and Seminar							1,607	1,607		24
25	Other Admin. Staff Transportation			3,339	3,339		3,339	15,426	18,765		25
26	Insurance-Prop.Liab.Malpractice			216,978	216,978		216,978	5,341	222,319		26
27	Other (specify):* related party/bad debt			72,870	72,870		72,870	(10,050)	62,820		27
28	TOTAL General Administration	187,146	15,090	1,426,587	1,628,823	16,139	1,644,962	67,606	1,712,568		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,997,131	593,669	1,839,833	5,430,633	(1,423)	5,429,210	111,204	5,540,414		29

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

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

Heather Health Care Center

#0023945

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			101,301	101,301		101,301	(12,495)	88,806			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			97,352	97,352		97,352	7,137	104,489			32
33	Real Estate Taxes			342,490	342,490	(342,490)		347,896	347,896			33
34	Rent-Facility & Grounds			8,544	8,544	342,490	351,034	(351,034)				34
35	Rent-Equipment & Vehicles			16,932	16,932		16,932	50,878	67,810			35
36	Other (specify):* MIP											36
37	TOTAL Ownership			566,619	566,619		566,619	42,382	609,001			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		181,909	283,315	465,224	1,423	466,647	(76,383)	390,264			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			364,524	364,524		364,524		364,524			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		181,909	647,839	829,748	1,423	831,171	(76,383)	754,788			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,997,131	775,578	3,054,291	6,827,000		6,827,000	77,203	6,904,203			45

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

Reclassifications - Pages 3 & 4, Column 5

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		\$ (30,888.00)	Employee Meals
	22	\$ 30,888.00	Employee Meals
22		\$ (15,413.00)	Uniforms
	1	\$ 1,551.00	Uniforms
	3	\$ 1,390.00	Uniforms
	4	\$ 365.00	Uniforms
	6	\$ 188.00	Uniforms
	10	\$ 11,214.00	Uniforms
	11	\$ 41.00	Uniforms
	21	\$ 664.00	Uniforms
10		\$ (1,423.00)	Oxygen - to appropriate cost center
	39	\$ 1,423.00	Oxygen - to appropriate cost center
33		\$ (342,490.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	\$ 342,490.00	Rent - Real Estate Tax on associated landowner (Pg 6)
19		\$ (385.00)	RC Employee Background Cost
	20	\$ 385.00	RC Employee Background Cost
		<u>\$ -</u>	

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,699)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(763)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(73)	2		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	(21,200)	21		17
18	Fines and Penalties	(300)	32		18
19	Entertainment	(54)	20		19
20	Contributions	11,731	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,085)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,870)	27		24
25	Fund Raising, Advertising and Promotional	(6,512)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (100,825)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	273,076		34
35	Other- Attach Schedule	(95,048)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 178,028		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 77,203		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heather Health Care Center

ID# 0023945

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (3,964)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(12,817)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	0	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	21,058	6	4
5				5
6	Elim ABC Deprec Exp from Pg 12 series -	748	30	6
7	Adj for ABC Related Party Profit - Pg 13	(452)	30	7
8				8
9				9
10	Late Fees on utilities	(4,725)	5	10
11				11
12	Intercompany interest is not allowed (gl 7031)	(94,080)	32	12
13				13
14	A/P Adjustments (vendor discounts)	(17)	10	14
15	Miscellaneous Income - Medical Records	(315)	10	15
16	Miscellaneous Income - Jury Duty	(69)	21	16
17	Collection Fees (gl6965)	(415)	21	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		(95,048)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heather Health Care Center# 0023945

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	2,584	(13,217)	0	0	0	0	0	0	0	(10,633)	1
2	Food Purchase	(73)	0	0	(32,470)	0	0	0	0	0	0	0	(32,543)	2
3	Housekeeping	0	0	8,661	0	0	0	0	0	0	0	0	8,661	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,725)	0	3,206	0	0	0	0	0	0	0	0	(1,519)	5
6	Maintenance	11,359	0	5,806	0	0	0	(34)	301	0	0	0	17,432	6
7	Other (specify):*	0	0	7,877	1,088	0	0	0	0	0	0	0	8,965	7
8	TOTAL General Services	6,561	0	28,134	(44,599)	0	0	(34)	301	0	0	0	(9,637)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(332)	0	48,991	(58)	(2,943)	0	0	0	0	0	0	45,658	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	7,577	0	0	0	0	0	0	0	0	7,577	15
16	TOTAL Health Care and Programs	(332)	0	56,568	(58)	(2,943)	0	0	0	0	0	0	53,235	16
	C. General Administration													
17	Administrative	0	0	121,563	0	0	0	0	0	0	0	0	121,563	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,085)	0	(347,204)	0	0	0	0	0	0	0	0	(348,289)	19
20	Fees, Subscriptions & Promotions	5,165	309	(21,003)	0	0	0	0	0	0	0	0	(15,529)	20
21	Clerical & General Office Expenses	(21,684)	0	280,229	28,744	10,248	0	0	0	0	0	0	297,537	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,607	0	0	0	0	0	0	0	0	1,607	24
25	Other Admin. Staff Transportation	0	0	15,426	0	0	0	0	0	0	0	0	15,426	25
26	Insurance-Prop.Liab.Malpractice	0	5,121	220	0	0	0	0	0	0	0	0	5,341	26
27	Other (specify):*	(72,870)	0	60,193	2,826	(199)	0	0	0	0	0	0	(10,050)	27
28	TOTAL General Administration	(90,474)	5,430	111,031	31,570	10,049	0	0	0	0	0	0	67,606	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(84,245)	5,430	195,733	(13,087)	7,106	0	(34)	301	0	0	0	111,204	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heather Health Care Center# 0023945

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(16,485)	0	3,990	0	0	0	0	0	0	0	0	(12,495)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(95,143)	0	102,076	0	204	0	0	0	0	0	0	7,137	32
33	Real Estate Taxes	0	342,490	5,431	0	(25)	0	0	0	0	0	0	347,896	33
34	Rent-Facility & Grounds	0	(351,034)	0	0	0	0	0	0	0	0	0	(351,034)	34
35	Rent-Equipment & Vehicles	0	0	50,878	0	0	0	0	0	0	0	0	50,878	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(111,628)	(8,544)	162,375	0	179	0	0	0	0	0	0	42,382	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(46,485)	(15,560)	(14,338)	0	0	0	0	0	(76,383)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(46,485)	(15,560)	(14,338)	0	0	0	0	0	(76,383)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(195,873)	(3,114)	358,108	(59,572)	(8,275)	(14,338)	(34)	301	0	0	0	77,203	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group, Ltd.	100	See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 351,034	Heather Health Care Center II, LLC	0.00%	\$	\$ (351,034)	1
2	V	33 Real Estate Tax Expense		Heather Health Care Center II, LLC		342,490	342,490	2
3	V	20 Dues & Subscriptions		Heather Health Care Center II, LLC		309	309	3
4	V	26 Property & Liability Insurance		Heather Health Care Center II, LLC		5,121	5,121	4
5	V			Heather Health Care Center II, LLC				5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 351,034			\$ 347,920	\$ * (3,114)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 3,206	\$	3,206	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		1,607		1,607	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		15,426		15,426	17
18	V	26 Insurance		Alden Management Services, Inc.		220		220	18
19	V	20 Dues/Subscriptions	24,816	Alden Management Services, Inc.		3,813		(21,003)	19
20	V	30 Depreciation		Alden Management Services, Inc.		3,990		3,990	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		5,431		5,431	21
22	V	35 Rent-Equip/Vehicles		Alden Management Services, Inc.		50,878		50,878	22
23	V	32 Interest		Alden Management Services, Inc.		102,076		102,076	23
24	V	1 Dietary Aide Coordinator Salary		Alden Management Services, Inc.		2,584		2,584	24
25	V	3 Housekeeping Coordinaor Salary		Alden Management Services, Inc.		8,661		8,661	25
26	V	7 Employee Benef %- Gen'l Servs		Alden Management Services, Inc.		7,877		7,877	26
27	V	10 Nurs & Med Records Salary		Alden Management Services, Inc.		48,991		48,991	27
28	V	15 Employee Benef %-Health Care		Alden Management Services, Inc.		7,577		7,577	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		121,563		121,563	29
30	V	27 Employee Benef %-Administrative		Alden Management Services, Inc.		60,193		60,193	30
31	V	19 Professional Fees	395,338	Alden Management Services, Inc.		48,134		(347,204)	31
32	V	21 Gen'l & Admin		Alden Management Services, Inc.		280,229		280,229	32
33	V	6 Repairs & Maintenance	40,008	Alden Management Services, Inc.		45,814		5,806	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 460,162			\$ 818,270	\$ *	358,108	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Consultant	\$ 25,500	Prism Health Care Services, Inc.	0.00%	\$ 61	\$ (25,439)
16	V	2 Tube Feeding	42,855	Prism Health Care Services, Inc.		10,385	(32,470)
17	V	10 Equipment Rental	6,660	Prism Health Care Services, Inc.		6,602	(58)
18	V						
19	V	39 Supplies	76,784	Prism Health Care Services, Inc.		30,299	(46,485)
20	V	1 Dietary Salary		Prism Health Care Services, Inc.		12,222	12,222
21	V	21 Gen'l & Admin Salary		Prism Health Care Services, Inc.		16,993	16,993
22	V	27 Employee Benefits		Prism Health Care Services, Inc.		2,826	2,826
23	V	7 Employee Benefits		Prism Health Care Services, Inc.		1,088	1,088
24	V	21 General & Administrative		Prism Health Care Services, Inc.		11,751	11,751
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 151,799			\$ 92,227	\$ * (59,572)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 <u>Drugs</u>	\$ 48,739	<u>Forum Extended Care Services II, Inc.</u>	0.00%	\$ 41,293	\$ (7,446)
16	V	39 <u>I.V.</u>	39,774	<u>Forum Extended Care Services II, Inc.</u>		33,698	(6,076)
17	V	39 <u>Wound Care</u>	13,342	<u>Forum Extended Care Services II, Inc.</u>		11,304	(2,038)
18	V	10 <u>House Stock</u>	15,118	<u>Forum Extended Care Services II, Inc.</u>		12,809	(2,309)
19	V	10 <u>Pharmacy Consultant</u>	4,152	<u>Forum Extended Care Services II, Inc.</u>		3,518	(634)
20	V	27 <u>Employee Vaccinations</u>	1,306	<u>Forum Extended Care Services II, Inc.</u>		1,107	(199)
21	V	21 <u>Employee Benefit: G & A</u>		<u>Forum Extended Care Services II, Inc.</u>		785	785
22	V	21 <u>Salary: G & A</u>		<u>Forum Extended Care Services II, Inc.</u>		5,203	5,203
23	V	21 <u>General & Administrative</u>		<u>Forum Extended Care Services II, Inc.</u>		4,260	4,260
24	V	32 <u>Interest</u>		<u>Forum Extended Care Services II, Inc.</u>		204	204
25	V	33 <u>Real Estate Tax</u>		<u>Forum Extended Care Services II, Inc.</u>		(25)	(25)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 122,431			\$ 114,156	\$ * (8,275)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy	\$ 291,554	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 277,216	\$ (14,338)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 291,554			\$ 277,216	\$ * (14,338)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs & Maintenance	\$ 18,059	Alden Bennett Construction Company, Inc.	0.00%	\$ 18,025	\$	(34)	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		\$ 18,059			\$ 18,025	\$ *	(34)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs & Maintenance	\$ 1,437	Alden Design Group, Inc.	0.00%	\$ 1,738	\$ 301	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 1,437			\$ 1,738	\$ *	301	39

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

Facility Name & ID Number

Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Home Office rental	1
2			Alden-Lincoln Park Rehabilitation and Health C	Chicago				2
3			Alden-Northmoor Rehabilitation and Health Ca	Chicago	Forum Extended Care	Chicago	Pharmacy	3
4			Alden-Lakeland Rehabilitation and Health Care	Chicago	Alden Management Se	Chicago	Management	4
5			Alden of Old Town East, Inc.	Bloomingtondale				5
6			Alden Terrace of McHenry Rehabilitation and F	McHenry	Alden Gardens of Bloo	Bloomingtondale	Supportive Living F	6
7			Alden - Wentworth Rehabilitation and Health C	Chicago	Alden Garden Courts	DesPlaines	Assisted Living/Alz	7
8			Alden Estates of Naperville, Inc.	Naperville	Alden Courts of Water	Aurora	Alzheimers Facility	8
9			Alden - Valley Ridge Rehabilitation and Health	Bloomingtondale	Alden Gardens of Wat	Aurora	Assisted Living	9
10			Alden Village Health Facility for Children and Y	Bloomingtondale	Prism Health Care Ser	Schaumburg	Nursing and Durabl	10
11			Alden - Orland Park Rehabilitation and Health	Orland Park	Community Physical T	Addison	Therapy Provider	11
12			Alden - Princeton Rehabilitation and Health Ca	Chicago	Alden Bennett Constr	Chicago	General Contractor	12
13			Alden of Old Town West, Inc.	Bloomingtondale	Fort Medical Equipme	Fort Atkinson, WI	Nursing and Durabl	13
14			Alden - Town Manor Rehabilitation and Health	Cicero	Alden Design Group, I	Chicago	Design & Engineeri	14
15			Alden Trails, Inc.	Bloomingtondale	Achieve Recovery and	Elmhurst	Rehab-substance ab	15
16			Alden - Poplar Creek Rehabilitation and Health	Hoffman Estates	Family Solutions for S	Addison	Private Duty Care	16
17			Alden - North Shore Rehabilitation and Health C	Skokie	Family Home Health S	Addison	Home health & hosj	17
18			Alden - Des Plaines Rehabilitation and Health C	Des Plaines				18
19			Alden Estates of Evanston, Inc.	Evanston				19
20			Alden - Alma Nelson Manor, Inc.	Rockford				20
21			Alden - Park Strathmoor, Inc.	Rockford				21
22			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				22
23			Alden Estates of Barrington, Inc.	Barrington				23
24			Alden of Waterford, LLC	Aurora				24
25			Alden Springs, Inc.	Bloomingtondale				25
26			Alden Village North, Inc.	Chicago				26
27			Alden Estates of Skokie, Inc.	Skokie				27
28			Alden Estates of Countryside, Inc.	Jefferson, WI				28
29			Alden Estates of Shorewood, Inc.	Shorewood, IL				29
30								30

Facility Name & ID Number Heather Health Care Center # 0023945 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	Floyd A. Schlossberg A.	President	CEO	100.00	178,281	1.452	3.63	Salary	\$ 6,719	17-7	1
2	Lauren Magnusson B.	Dir. Of Clinical Servi	Technical Nursing	0.00	91,550	1.452	3.63	Salary	3,450	10-7	2
3	Terry Magnusson C.	Dir. of Purchasing	Supervise Mainten	0.00	91,550	1.452	3.63	Salary	3,450	6-7	3
4	Ina Schlossberg D.	Board Member	General Operation	0.00	96,600	1.452	3.63	Salary	3,641	17-7	4
5	Audra Elisco F.	Training Coordinator	Train employees	0.00	58,715	1.452	3.63	Salary	2,213	21-7	5
6											6
7	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										8
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers.										9
10	D. Ina Schlossberg is the wife of Floyd Schlossberg. Ina is on the Board of Directors and participates in the general operations of the company.										10
11	E. Audra Elisco is the daughter of Floyd Schlossberg. Audra is a training coordinator for our Quality Assurance Program.										11
12											12
13								TOTAL	\$ 19,473		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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773-286-3883
 Fax Number (773-286-8038

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Patient Days	1,278,025	35	\$ 88,281	\$ 46,415	\$ 3,206	1	
2	24	Trav & Seminar	Patient Days	1,278,025	35	44,237	46,415	1,607	2	
3	25	Other Admin Travel	Patient Days	1,278,025	35	424,738	46,415	15,426	3	
4	26	Insurance	Patient Days	1,278,025	35	6,060	46,415	220	4	
5	20	Dues & Subscriptions	Patient Days	1,278,025	35	104,997	46,415	3,813	5	
6	30	Depreciation	No of Providers/usage	35	35	150,051	1	3,990	6	
7	33	Real Estate Tax	Patient Days/usage	1,278,025	35	171,564	46,415	5,431	7	
8	35	Rent-Equip & Vehicle	Patient Days	1,278,025	35	1,400,909	46,415	50,878	8	
9	32	Interest	Patient Days/usage	1,278,025	35	2,235,440	46,415	102,076	9	
10	1	Dietary Salary	Patient Days	1,278,025	35	71,149	71,149	46,415	2,584	10
11	3	Housekeeping Salary	Patient Days	1,278,025	35	238,482	238,482	46,415	8,661	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,278,025	35	216,885	46,415	7,877	12	
13	10	Nurs & Med Records Salary	Patient Days	1,278,025	35	1,414,605	1,414,605	46,415	48,991	13
14	15	Employee Benefits -Health Care	Patient Days	1,278,025	35	208,622	46,415	7,577	14	
15	17	Administrative Salary	Patient Days/usage	1,278,025	35	3,718,414	3,718,414	46,415	121,563	15
16	27	Employee Benefits - Admin	Patient Days	1,278,025	35	1,657,386	46,415	60,193	16	
17	19	Professional fees	Patient Days	1,278,025	35	1,311,498	850,594	46,415	48,134	17
18	21	Gen'I & Admin	Patient Days	1,278,025	35	7,716,027	6,669,245	46,415	280,229	18
19	6	Repair & Maint.	Patient Days	1,278,025	35	1,444,891	1,161,005	46,415	45,814	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 22,624,236	\$ 14,123,494	\$ 818,270	25	

Facility Name & ID Number

Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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	Insurance Interest (GL07053)		X	Medical Malpractice							2,972	4					
5												5					
	Working Capital																
6	Related party-AMS		X	Working Capital							102,076	6					
7	Related party-FECII		X	Working Capital							204	7					
8												8					
9	TOTAL Facility Related						\$	\$			\$	105,252	9				
	B. Non-Facility Related*																
10	Int Income (GL#4975)										(763)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	(763)	14				
15	TOTALS (line 9+line14)						\$	\$			\$	104,489	15				

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2013 report.	\$	327,600		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.)	\$	330,090		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	2,490		3
4.	Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	340,000		4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	342,490		7
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax		\$	5,406.00
		Total Real Estate Tax Expense, Sch V, Line 33		\$	347,896
Real Estate Tax Bill for Calendar Year:				FOR BHF USE ONLY	
	2009	<u>427,261</u>	8	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2010	<u>228,642</u>	9	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2011	<u>290,319</u>	10	15	LESS REFUND FROM LINE 6 \$ 15
	2012	<u>318,044</u>	11	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
	2013	<u>330,090</u>	12		
The current year accrual is based on an estimated 3% increase of the prior year tax					

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.

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 x NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,971 B. General Construction Type: Exterior Brick/Concrete Frame Steel Number of Stories 1, Partial 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>nursing facility</u>	<u>62,115</u>	<u>2005</u>	<u>\$ 187,500</u>	1
2					2
3	TOTALS	62,115		\$ 187,500	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	LAND IMPROVEMENT/ROOFING/HVAC		1980	168,496		10-27			168,496
10	PAVING/PAINTING/DRAINAGE TILE		1981	13,153		10-30			13,153
11	ROOFING		1983	3,100		12			3,100
12	DOOR WINDOW/BEARING ASSEMBLE/WATER PUMP		1984	15,805		5			15,805
13	ROOFING/HEAT EXCHANGE/MOTOR/BASEBOARD		1985	17,603		8-10			17,603
14	ROOF REPAIR/SEAL PARKING LOT/HEAT EXCHANGE		1986	40,170		2-10			40,170
15	COMPRESSOR REPR/INSTLL FLOW/SWTCH/REWIRE ALARM		1988	22,171		5 &10			22,171
16	ANDERSON (ELEVATOR UV5 VALVE)		1990	1,577		5			1,577
17	REPL HEAT EXCHANGE/ROOFTOP EXHST/RE-BRICK WALL		1991	22,663		5-25			22,663
18	HOT WATER TANK/SEWER REPAIR		1992	15,092		5 &15			15,092
19	SEWAGE EJECTOR/VALVE/MOTOR/WINDOW REPAIR		1993	20,312		5&10			20,312
20	ROOF REPAIR/BOILER/PUMP REPAAIR/ALARM REPAIR/WINDC		1994	45,851		3			45,851
21									
22	ALARM REPAIR/LOCK SET&KEYS/FLOOR REPAIR/FLOOR TILE		1995	44,195	446	3-20	446		44,195
23									
24	TILE INSTALLED & REPAIR CORRIDOR		1996	1,558		10			1,558
25	REMOVED & REPLACED NEW MOTOR		1996	3,292		10			3,292
26	REMOVED & INSTALLED NEW MOTOR		1996	1,714		10			1,714
27	ELECTRICAL REPAIR		1996	3,127	156	20	156		2,918
28	WINDOW REPAIR		1996	6,466	323	20	323		6,008
29	VALVE REPAIR		1996	1,523		15			1,523
30	BOILER LEAKING		1996	6,876		15			6,876
31	WINDOW REPAIR		1996	2,713	136	20	136		2,453
32	INSTALL ASPHALT		1996	16,215		10			16,215
33									
34	INSTALL DOOR FRAME		1997	2,517		10			2,517
35	INSTALL VENT PIPE FOR DRYER		1997	6,180		5			6,180
36	INSTALL TILE		1997	1,706		5			1,706

*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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	REPLACE BOILER ROOM- TOP A/C	1997	\$ 6,000	\$	5	\$	\$	\$ 6,000	37
38	INSTALL GAS PIPE	1997	4,220		5			4,220	38
39	INSTALL NEW VALVE AND RECOPPER	1998	1,864		5			1,864	39
40	PIPING	1998	7,104	284	25	284		4,784	40
41	ROOF REPAIR	1998	2,920		10			2,920	41
42	REPAIR & CHECK VOLTAGE OUTPUT	1998	1,780		5			1,780	42
43	REPLACED VALVE - HOT WATER	1998	3,270		5			3,270	43
44	REMODELED & DECORATED ROOMS	1998	28,760		15			28,760	44
45	WHIRLPOOL TURBINE	1998	1,599		5			1,599	45
46	REPLACE EXHAUST FAN	1998	1,950		15			1,950	46
47	FIX FLOOR TILE	1998	3,626		10			3,626	47
48	INSTALL DOOR MONITORING SYSTEM	1998	1,587		10			1,587	48
49	INSTALL SECURITRON ANNUNCIATOR	1998	1,764		10			1,764	49
50	REPLACE BOILER ON STEAMER	1998	4,283		10			4,283	50
51	INSTALL RESET CONTROL ON BOILER	1998	3,900	195	20	195		3,201	51
52	WRAP CHILLER PIPES	1998	2,682	134	20	134		2,168	52
53	REPLACE PUMP MOTOR	1998	4,425		15			4,425	53
54	PAINT	1998	7,845		20			7,845	54
55	CLIMATE SERICE (CLEANED BOILER, VALVE)	1999	1,374	69	20	69		1,099	55
56	CLIMATE SERVICE (REPLACE MISING VALVE	1999	3,317		15			3,317	56
57	CLIMATE SERVICE (INSTALLL HOT WATER HEATER)	1999	7,391	41	15	41		7,391	57
58	CLIMATE SERVICE (INSTALL ROOF TOP REPLACEMENT)	1999	9,935		10			9,935	58
59	CLIMATE SERVICE (REPAIR HEATING UNIT)	1999	1,643	18	15	18		1,643	59
60	ENVIRON VISION ENVIRONMENT	1999	2,919		10			2,919	60
61	CHICAGO COOLING CORP (SHUTDOWN BOILER & AC	1999	2,117		10			2,117	61
62	ABC CARPENTRY	1999	2,031		10			2,031	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 604,381	\$ 1,803		\$ 1,803	\$	\$ 599,646	70

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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014 Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 604,381	\$ 1,803		\$ 1,803	\$	\$ 599,646	1
2	ABC WINDOW SCREENS	1999	3,916		10			3,916	2
3	ABC INSULATION	1999	3,203		10			3,203	3
4	CLIMATE SERVICE, INC. (INSTALL CONDENSER)	1999	4,565	152	15	152		4,565	4
5	WIGDAHL ELECTRIC (RECEPTACLES INSTALLED)	1999	5,457	273	20	273		4,229	5
6	CLIMATE SERVICE, INC. (REPLACE MOTOR ON FAN)	1999	2,772		10			2,772	6
7	CLIMATED SERVICE, INC. - REPLACE FAN MOTOR	1999	1,693		10			1,693	7
8	ADVANCED PARTS -GARBAGE DISPOSAL	1999	6,515		5			6,515	8
9	THE FLOOR SOURCE -INSTALL CARPET	1999	2,469		5			2,469	9
10	FOX VALLEY FIRE & SAFETY-DOOR ALARM SYSTEM	1999	2,540	141	15	141		2,540	10
11	CLIMATE SERVICE, INC.-BOILER	1999	8,437	422	20	422		6,363	11
12	ABC - GENERAL	1999	4,099		10			4,099	12
13	ABC ROOF	1999	2,501		10			2,501	13
14	ABC HARDWARE	1999	1,793		10			1,793	14
15	CLIMATE SERVICE, INC. REPAIR BURNER	1999	1,615		10			1,615	15
16									16
17	FOX VALLEY FIRE & SAFETY -SMOKE DETECTORS	1999	7,500		10			7,500	17
18	DELETE ABOVE ITEM	2000	(7,500)		10			(7,500)	18
19	ABC-BUILDING CONSTRUCTION/VARIOUS	2000	3,244		10			3,244	19
20	FOX VALLEY -SMOKE DETECTORS	2000	7,500		10			7,500	20
21	FOX VALLEY-DOOR ALARMS	2000	1,931		10			1,931	21
22	LONG ELEVATOR-ATTACHMENTS	2000	1,751	88	20	88		1,313	22
23	CLIMATE SERVICES-BOILER ROOM	2000	4,422	221	20	221		3,298	23
24	CI-SERVICE DRAPES/RODS	2000	9,460		5			9,460	24
25	ADJUST 1999 TOTAL TO CORRECT AMOUNTS	2000	10		10			10	25
26	ABC-BUILDING MAINT CONSTRUCT-VARIOUS	2000	19,015		10			19,015	26
27	NEW HORIZONS-TELEPHONEE SYSTEM	2000	1,670		10			1,670	27
28	ABC-SEAL & STRIPE PARK. LOT	2000	4,154		10			4,154	28
29	CSI CORKER SERVICE	2001	4,773	239	20	239		3,222	29
30	ABC-TIME & MATERIAL BILLING (JULY 2001)	2001	6,028		10			6,028	30
31	ABC-TIME & MATERIAL BILLING (OCT 2001)	2001	7,272		10			7,272	31
32	CAPPS PLUMBING	2001	12,236		10			12,236	32
33	GT MECHANICAL - WATER HEATER	2001	4,559	304	15	304		4,027	33
34	TOTAL (lines 1 thru 33)		\$ 743,981	\$ 3,642		\$ 3,642	\$	\$ 732,298	34

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

Facility Name & ID Number Heather Health Care Center

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 743,981	\$ 3,642		\$ 3,642	\$	\$ 732,298	1
2	Retile Basement Corridor 1	2002	3,650		10			3,650	2
3	Retile Basement Corridor 2	2002	3,650		10			3,650	3
4	Replace 4 Windows	2002	782		10			782	4
5	Replace 10 Windows	2002	2,204		10			2,204	5
6	Repiping 15' 2" galv pipe	2002	1,165	47	25	47		590	6
7	Replace RPZ Valve main Boiler Room	2002	545	36	15	36		466	7
8	Replace RPZ Valves 1 small Boiler Room	2002	1,865	124	15	124	0	1,596	8
9	Replace 3 outside valves	2002	1,165	78	15	78		964	9
10	ABC - Replace doors	2002	4,103		10			4,103	10
11	Security Services - Keypad entry system	2002	1,575	105	15	105		1,269	11
12	Security Services - Door Alarm System	2002	2,035	136	15	136		1,639	12
13	CAPPS Replace Drain Line	2002	2,965	148	20	148		1,903	13
14	GT Mechanical - replace chiller condensor motor	2002	2,876	192	15	192		2,381	14
15	GT Mechanical - Replace Bearing assem. Big Boiler	2002	1,357	90	15	90		1,168	15
16	GT Mechanical - Hot water circ pump lg. Boiler room	2002	698	47	15	47		605	16
17	CSI - Replace valves, steamer & timer on ovens	2002	1,761	117	15	117		1,526	17
18	Healthcare Products - Repair wheelchairs	2002	2,282		3			2,282	18
19	CAPPS - Repair Sprinkler System	2002	1,165	78	15	78		964	19
20	GT Mechanical - Repair Heater	2002	1,658	111	15	111		1,354	20
21	A&B Custom Cabel install 21 cable outlets	2003	1,731		10			1,731	21
22	ABC - New floor in PT Room	2003	3,896		10			3,896	22
23	A&B Custom Cabel install 27 cable outlets	2003	2,318		10			2,318	23
24	A&B Custom Cabel install 97 cable outlets	2003	6,969		10			6,969	24
25	Security Service - Door alarm service	2003	2,284	152	15	152		1,751	25
26	Capps - Repair 1st floor drains	2003	1,553		10			1,553	26
27	GT Mech- Repair water pump	2003	1,674		5			1,674	27
28	CSI - Repair Dishwasher	2003	1,953		5			1,953	28
29	Capps - Repair Sewer	2003	3,755	250	15	250		2,900	29
30	New Horizons Comm - Repair Phone system	2003	1,908		5			1,908	30
31	Capps - New Laundry Tub 1of2	2003	1,800		10			1,800	31
32	Capps - New Laundry Tub 2of2	2003	2,214		10			2,214	32
33	New Horizons Comm - Repair Phone system	2003	2,897		5			2,897	33
34	TOTAL (lines 1 thru 33)		\$ 816,434	\$ 5,352		\$ 5,352	\$ 0	\$ 798,958	34

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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014 Ending: 12/31/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 816,434	\$ 5,352		\$ 5,352	\$ 0	\$ 798,958	1
2	Forum Prof Ctr: Remodeling	1979	15,638		20			15,057	2
3	Forum Prof Ctr: Build Improv - multiple	1980	30,456		15			29,324	3
4	Forum Prof Ctr: Tennant Improv	1986	961		13			925	4
5	Forum Prof Ctr: AMS remodel	1990	6,532		10			6,289	5
6	Forum Prof Ctr: Roof	1994	3,445		16			3,317	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,215		16			1,170	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,919	15	10	15		1,915	8
9	Forum Prof Ctr: Remodel/electrical	2001	747	14	7	14		734	9
10	Forum Prof Ctr: bathroom remodel	2002	661		5			661	10
11	Forum Prof Ctr: remodel suites/etc.	2003	850		9			850	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,616	79	7	79		2,555	12
13	Forum Prof Ctr: Suite renovation	2005	528	(13)	10	(13)		587	13
14	Forum Prof Ctr: Superior installations, etc.	2006	126		4			126	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	508	48	7	48		508	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	436	50	7	50		398	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	887	85	10	85		445	17
18	Forum Prof Ctr: Building Renovations	2010	1,511	267	5	267		1,276	18
19	Forum Prof Ctr: Building Renovations	2011	6,625	656	10	656		2,163	19
20	Forum Prof Ctr: Building Renovations	2012	288	39	15	39		117	20
21	Forum Prof Ctr: Building Renovations	2013	432	26	7	26		51	21
22	Forum Prof Ctr: Elect Install/sewer excavation	2014	440	12		12		12	22
23	Alden Mgt Servs: Remodel suites	1993	6,963		10			6,963	23
24	Alden Mgt Servs: Remodel suites	2002	290	4	13	4		286	24
25	Alden Mgt Servs: Remodel suites	2003	6,295	12	11	12		6,295	25
26	Alden Mgt Servs: Motor Controller PC Board	2014	86	10		10		10	26
27									27
28	Adjust for ABC Related Party Profit	2008	(73)	(10)		(10)		(42)	28
29	Adjust for ABC Related Party Profit	2009	(86)	(12)		(12)		(32)	29
30	Adjust for ABC Related Party Profit	2011	(168)	(24)		(24)		(57)	30
31	Adjust for ABC Related Party Profit	2012	5,558	794		794		1,588	31
32	Adjust for ABC Related Party Profit	2013	177	12		12		24	32
33	Adjust for ABC Related Party Profit	2014	(47)	(1)		(1)		(1)	33
34	TOTAL (lines 1 thru 33)		\$ 912,251	\$ 7,415		\$ 7,415	\$ 0	\$ 882,472	34

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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014 Ending: 12/31/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 912,251	\$ 7,415		\$ 7,415	\$ 0	\$ 882,472	1
2	ABC - Repair Roof	2003	10,191		10			10,191	2
3	CSI - Repair Drain	2003	1,768		5			1,768	3
4	CAPPS - CLEAR BASIN & CLEAN DRAIN	2004	975		5			975	4
5	CAPPS - POWER RODDED MAIN SEWER	2004	1,720		5			1,720	5
6	CSI - WATER HEATER PARTS AND REPAIR	2004	1,760	44	10	44		1,760	6
7	ABC - REPAIR LEAKY ROOF	2004	3,203		5			3,203	7
8	TNS/TERMINX - PEST CONTROL DRVC OF 6 LOCATIONS	2004	2,028		5			2,028	8
9	ABC - HVAC WORK/INSULATION	2004	7,090	236	10	236		7,090	9
10	ABC - WATER HEATER	2004	8,891	74	10	74		8,891	10
11	Top Notch - Door & Frame w/Hardware	2005	3,595	360	10	360		3,415	11
12	ABC - Bathroom Repairs	2005	4,307	431	10	431		4,307	12
13	CAPPS - Install new Basin, backflow valave in manhole	2005	4,200		5			4,200	13
14	CAPPS - Replaced Pipe, Power Rodded	2005	2,400		5			2,400	14
15	ABC - Bathroom Repairs	2005	10,661	1,066	10	1,066		10,483	15
16	GT Mechanical - Repair Boiler	2005	4,334	433	10	433		4,225	16
17	CAPPS - New RPZ	2005	1,965	197	10	197		1,916	17
18	GT Mechanical - Bell and Gosset Bearing Assembly/GE Motor	2005	2,398	240	10	240		2,298	18
19	Cybor Fire Protection - Sprinkler System Pipe Work	2005	2,985		5			2,985	19
20	Oak Fire - Alarm Repair (new pit, connect Ansul to Fire Alarm, In	2005	4,980	498	10	498		4,731	20
21	ABC - Bathroom Repairs	2005	14,900	1,490	10	1,490		13,907	21
22	Long Elevator - Repairs to electric eye	2005	1,509	75	20	75		698	22
23	ABC - New Outdoor Sign Install	2005	1,637	136	12	136		1,239	23
24	ABC - New Mental Institution Unit	2006	32,303	1,615	20	1,615		12,920	24
25	GT MECH - new thermostats-repair	2006	3,355		5			3,355	25
26	Top Notch- Replace Sink Heater	2006	2,975	298	10	298		2,653	26
27	Roof Repairs	2006	3,060	306	10	306		2,550	27
28	GT MECH - Repair thermostat and replaced blower	2006	5,077	508	10	508		4,062	28
29	AMS-Generator Install remote Annunicator	2006	3,192	213	15	213		1,897	29
30	AC Compressor and Repair	2006	10,386	692	15	692		5,770	30
31	ABC - Fire ID plate and sprinkler system repairs	2006	10,563	704	15	704		5,692	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,080,658	\$ 17,031		\$ 17,031	\$ 0	\$ 1,015,802	34

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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014 Ending: 12/31/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,080,658	\$ 17,031		\$ 17,031	\$ 0	\$ 1,015,802	1
2	New MI Unit	2007	9,497	950	10	950		7,283	2
3	Masonry	2007	43,549	2,903	15	2,903		20,806	3
4	Hot Water Storage	2007	5,984	598	10	598		4,737	4
5	Compressor Contractor	2007	7,052	470	15	470		3,722	5
6	Heating/Vent	2007	9,645	964	10	964		7,635	6
7	Cubicle Repair	2007	3,015	302	10	302		2,387	7
8	Lockset Replacement	2007	2,538	254	10	254		1,988	8
9	Roof Replacements	2007	3,556	356	10	356		2,756	9
10	Duct Work	2007	3,201	160	20	160		1,240	10
11	Fan Motor and Compressor	2007	3,696	370	10	370		2,803	11
12	New Paving	2007	14,960	1,870	8	1,870		13,869	12
13	New Carpet	2007	3,101		5			3,101	13
14	New Roof Installation	2007	4,956	496	10	496		3,675	14
15	Refrigeration Leak Repair	2007	5,864	586	10	586		4,349	15
16	Circulation Pump	2007	6,842	684	10	684		5,018	16
17	New Hot Water Heater	2007	8,605	861	10	861		6,167	17
18									18
19	ABC-Key Pad Replacements	2008	3,798		5			3,798	19
20	GT Mechanical-Dining Area	2008	3,933	393	10	393		2,688	20
21	Top Notch - Evaporator Assembly w/parts	2008	2,892	289	10	289		1,904	21
22	ABC - Repair south wing Roof	2008	6,404	640	10	640		4,163	22
23	Top Notch - Condensing Unit	2008	3,919	261	15	261		1,698	23
24	GT Mechanical - Dining Room Compressor Motor	2008	3,069	307	10	307		1,995	24
25	GT Mechanical - Motor & Bearing Assembly	2008	2,960	296	10	296		1,924	25
26	GT Mechanical - New Oil Pump	2008	2,802		5			2,802	26
27	ABC- New Plumbing Fixtures/35 New Windows	2008	2,630	132	20	132		811	27
28	ABC - New MI Unit	2009	36,050	2,403	15	2,403		14,620	28
29	ABC - New Security Fence	2009	6,519	435	15	435		2,390	29
30	J.D. & Sons - New Roofing Material - Partial	2009	5,000	500	10	500		2,708	30
31	J.D. & Sons - New Roofing Material	2009	15,000	1,500	10	1,500		8,125	31
32	Top Notch - New Booster	2009	5,406	360	5	360		5,406	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,317,101	\$ 36,370		\$ 36,370	\$ 0	\$ 1,162,370	34

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

Facility Name & ID Number Heather Health Care Center

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,317,101	\$ 36,370		\$ 36,370	\$ 0	\$ 1,162,370	1
2	Roof Flat and Mansard - ALDBEN	2010	8,187	819	10	819		3,480	2
3	Asphalt Parking Lot Sealcoat - ALDBEN	2010	5,556	694	8	694		2,951	3
4									4
5	Fan Condenser Sprinkler - GTMECH	2011	5,593	1,119	5	1,119		4,008	5
6	Dishwasher Repipe Disconnect - BELEC	2011	3,184	637	5	637		2,016	6
7									7
8	Fire Sprinkler Pump Conversion - ALDBEN	2012	39,531	1,581	25	1,581		4,612	8
9	Fire Sprinkler Pump Conversion - ALDBEN	2012	45,723	1,829	25	1,829		5,182	9
10	Fire Sprinkler Pump Conversion - ALDBEN	2012	4,763	191	25	191		524	10
11	Repair,new Motor,Inducer,Exchanger,Heat - GTMECH	2012	6,091	609	10	609		1,827	11
12	Repair Dishwasher - Reducer,Speed - TOPNOT	2012	3,516	703	5	703		2,051	12
13									13
14	Fire Protection System, Dry Pipe Sprinkler System - ALDBEN	2013	5,426	271	20	271		497	14
15	Fire Protection System, Dry Pipe Sprinkler System - ALDBEN	2013	4,807	240	20	240		360	15
16	Fire Protection, Power, Dry Sprinkler System - OAKFIR	2013	8,131	407	20	407		610	16
17	Asphalt Paving - ALDBEN	2013	2,943	368	8	368		491	17
18									18
19	Room, Built Electric Room - ALDBEN	2014	6,248	208	15	208		208	19
20	Fire Sprinklers - ALDBEN	2014	18,337	229	20	229		229	20
21	Elevator, Repair - KONINC	2014	15,248	1,271	5	1,271		1,271	21
22	Chiller Circuit Repair - GTMECH	2014	10,512	701	5	701		701	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)		\$ 1,510,895	\$ 48,247		\$ 48,247	\$ 0	\$ 1,193,388	34

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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	\$ 369,204	\$ 34,464	\$ 34,464	\$	varies	\$ 199,899	71
72	Current Year Purchases	91,290	3,713	3,713		varies	3,678	72
73	Fully Depreciated Assets	513,277	2,382	2,382		varies	513,277	73
74								74
75	TOTALS	\$ 973,771	\$ 40,559	\$ 40,559	\$		\$ 716,854	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	related party-AMS	various	1998-2004	4,026				3	4,026	77
78										78
79										79
80	TOTALS			\$ 4,026	\$	\$	\$		\$ 4,026	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,676,192	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,806	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,806	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,914,268	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party Cost is Eliminated

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning 7/1/2005

Ending 6/30/2015

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2015 \$ varies

13. 12/31/2016 \$ varies

14. 12/31/2017 \$ varies

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 31,941 Description: copy machine GL 6861 and equipment lease GL 6859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related party-Pg 6A</u>	<u>various</u>	\$ <u>#####</u>	\$ <u>18,705</u>	17
18					18
19			<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>18,705</u>	21

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

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

Facility Name & ID Number Heather Health Care Center # 0023945 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 115,852	\$		\$ 115,852	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,780			12,780	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			149,478			149,478	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescripts				41,293		41,293	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-1, 39-3, if any								12
13	Other (specify):	See Pg 16A				(14,338)	85,199		70,861	13
14	TOTAL			\$		\$ 263,772	\$ 126,492		\$ 390,264	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.

XIV. Special Services (Direct Cost)

Page 16
Col 5: PT,OT, & ST
Col 6: Supplies

Line	Service	Col. 1:	Ref. No.	To Pg 16:	Col. No.		
1.	OT		39-3	To Col 5		\$115,852.00	
2.	ST		39-3	To Col 5		12,780.00	
3.							
4.	PT		39-3	To Col 5		149,478.00	
5.							
6.							
7.							
8.							
	Pharmacy Supplies per GL					48,739.00	
	Manual Input from Related Party- Forum Drugs					(7,446.00)	
9.	Total to line 9 Pharmacy	See Pg 16		To Col 6		41,293.00	319,403.00
10.							
11.							
12.	Exceptional Care-Salaries:	See pg 16A		To Col. 3		0.00	
12.	Exceptional Care-Supplies:	See pg 16A		To Col. 6		0.00	
	Total Exceptional Care (Line 12, Col 8)					0.00	0.00
13.	Other:	See Pg 16A					

13. Col 5: Manual Input: Related Party - CPT	To Col 5		(14,338.00)
Other		138,375.00	
Manual Input: Related Party - Prism		(46,485.00)	
Manual Input: Related Party FECII - I.V.		(6,076.00)	
Manual Input: Related Party FECII - Wound Care		(2,038.00)	
Oxygen, from reclass worksheet (Pg 4A)		1,423.00	
13. Col 6: Supplies Total	To Col 6	85,199.00	85,199.00
13. Total Line 13, Column 8		0.00	70,861.00
14. Total		0.00	390,264.00

Facility Name & ID Number Heather Health Care Center# 0023945Report Period Beginning: 01/01/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>65,000</u>)	1,181,540	1,181,540	3
4	Supply Inventory (priced at)	3,402	3,402	4
5	Short-Term Investments			5
6	Prepaid Insurance		4,622	6
7	Other Prepaid Expenses	10,552	10,552	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd party</u>	621	621	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,196,115	\$ 1,200,737	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		197,659	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,368,336	1,368,336	15
16	Equipment, at Historical Cost	1,011,170	1,011,170	16
17	Accumulated Depreciation (book methods)	(1,748,969)	(1,748,969)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 630,537	\$ 828,196	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,826,652	\$ 2,028,933	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 413,471	\$ 413,471	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,165	44,165	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	375,770	375,770	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,006	14,006	31
32	Accrued Real Estate Taxes(Sch.IX-B)		340,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accr INS, Exps, IDPA, Sales Tx, etc.</u>	173,557	173,557	36
37	<u>Due to affiliates (short term)</u>	635,729	13,110	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,656,698	\$ 1,374,079	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Affiliates (long term)</u>	12,859,597	12,859,597	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,859,597	\$ 12,859,597	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,516,295	\$ 14,233,676	46
47	TOTAL EQUITY(page 18, line 24)	\$ (12,689,643)	\$ (12,204,743)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,826,652	\$ 2,028,933	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (12,889,210)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (12,889,210)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	199,567	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)	\$ 199,567	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)	\$ (12,689,643)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,957,496	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,957,496	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,530	6
7	Oxygen	8,275	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 67,805	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	763	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 763	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See page 19A, if any	503	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 503	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,026,567	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,379,469	31
32	Health Care	2,422,341	32
33	General Administration	1,628,823	33
B. Capital Expense			
34	Ownership	566,619	34
C. Ancillary Expense			
35	Special Cost Centers	465,224	35
36	Provider Participation Fee	364,524	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,827,000	40
41	Income before Income Taxes (line 30 minus line 40)**	199,567	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,567	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,029,974	44
45	Private Pay - Net Inpatient Revenue	7,873	45
46	Medicare - Net Inpatient Revenue	745,933	46
47	Other-(specify) <u>Hospice/Insurance</u>	173,716	47
48	Other-(specify) <u>Veterans/Sales Allow.</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,957,496	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet avail. 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.

STATE OF ILLINOIS

Facility Name & ID Number Heather Health Care Center # 0023945 Report Period Beginning: 01/01/2014 Ending:

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Misc. Income GL#4977 (discribe) (is offset against Sch.# V)	
Miscellaneous Income - Medical Records	\$ 315
Miscellaneous Income - Jury Duty	\$ 69
Adjustment to prior year expense	\$ 102
Vendor Discounts	\$ 17

Line 28 Total: 503

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

12/31/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,120	2,142	\$ 90,208	\$ 42.11	1
2	Assistant Director of Nursing	2,080	2,080	65,393	31.44	2
3	Registered Nurses	11,594	12,199	341,620	28.00	3
4	Licensed Practical Nurses	25,210	27,144	693,148	25.54	4
5	CNAs & Orderlies	56,503	61,351	653,715	10.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	39,020	18.76	9
10	Activity Assistants	6,510	7,029	73,486	10.45	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	38,751	18.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,196	16,589	191,394	11.54	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	60,793	29.23	17
18	Housekeepers	16,797	18,430	212,225	11.52	18
19	Laundry	5,116	5,861	66,580	11.36	19
20	Administrator	2,080	2,080	101,276	48.69	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	36,145	17.38	22
23	Office Manager	2,080	2,080	28,314	13.61	23
24	Clerical	2,326	2,418	21,411	8.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,000	2,000	62,482	31.24	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Clin Dir, Behav He</u>	10,175	11,166	221,170	19.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,107	180,889	\$ 2,997,131 *	\$ 16.57	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$2,150 Monthly	25,800	1-3	35
36	Medical Director	\$1,500 Monthly	18,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	\$346 Monthly	4,152		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	880	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	\$ 48,832		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	\$345 Monthly	4,142	10-3	52
53	TOTAL (lines 50 - 52)		\$ 4,142		53

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Valarie Kay</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 101,276</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 134,542</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>31,715</u>	<u>Advertising: Employee Recruitment</u>		
				<u>FICA Taxes</u>	<u>223,439</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>49,884</u>	<u>(Indicate # of checks performed <u>30</u>)</u>	<u>965</u>	
				<u>Employee Meals</u>	<u>30,888</u>	<u>Patient Background Checks</u>	<u>1,150</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Ill Health Care Association</u>	<u>(1,038)</u>	
				<u>Union,Health, Welfare</u>	<u>94,270</u>	<u>Surety Bonds</u>	<u>941</u>	
				<u>Dental & Life Insurance</u>	<u>1,495</u>	<u>Collaborative Healthcare/Health Care Council</u>	<u>9,550</u>	
				<u>Pension</u>	<u>18,601</u>	<u>Corporate Annual Report/Secretary of State</u>	<u>309</u>	
				<u>Misc Payroll Costs/401K Match</u>	<u>1,429</u>	<u>Related party- AMS, LLC</u>	<u>3,813</u>	
				<u>Employee Drug Test/Vaccinations</u>	<u>2,154</u>	<u>Less: Public Relations Expense</u>	<u>()</u>	
				<u>Employee Relations/Employee Dishonesty</u>	<u>13,674</u>	<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 101,276	TOTAL (agree to Schedule V, line 22, col.8)	\$ 602,091	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,690	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	<u>Related party- AMS</u>	<u>1,607</u>
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Alden Management Services</u>	<u>Consulting Fees</u>		<u>\$ 348,430</u>					
<u>BDO Seidman/Virchow Krause</u>	<u>Accounting Fees</u>		<u>9,237</u>					
<u>MIDCAP</u>	<u>Accounting Fees</u>		<u>1,166</u>					
<u>Mercer</u>	<u>Accounting Fees</u>		<u>400</u>					
<u>CICENT First Adv Corp</u>	<u>Accounting Fees</u>		<u>3,396</u>					
<u>AMS (Eliminated)</u>	<u>Tax Consultants</u>		<u>46,908</u>					
<u>Clerk of the CC/Recorder/Sheriff</u>	<u>Legal Fees: Non-Collection</u>		<u>143</u>					
<u>Leonard Smith/Ariana Fisch/Markle</u>	<u>Legal Fees:Collections</u>		<u>220</u>					
<u>Clerk of the Circuit Court</u>	<u>Legal Fees:Collections</u>		<u>572</u>					
<u>Markley Investigations Inc.</u>	<u>Legal Fees:Collections</u>		<u>150</u>					
<u>KPMG/C. Novotny</u>	<u>Cost Reports</u>		<u>216</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 410,838				<u>Entertainment Expense</u>	<u>()</u>
(For legal fee disclosure, see page 39 of instructions)							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,607

* Attach copy of IMRF notifications

**See instructions.

Heather Health Care Center
 Legal Fee Support
 2014

Legal Fees Reported on Pg 21, Section C:	\$	47,993.00
Less: Collection, estates, & other non-allowable legal fees listed on Pg 5, Line 22		(1,085.00)
Non-allowable legal fees, if any, deducted on - Pg 6A (AMS Allocated Legal Fees)		(46,908.00)
+ Add Back voided invoice of prior year, if any		<u> </u>
Allowable Legal Fees	<u>\$</u>	<u> -</u>

In Detail:

<u>Vendor Name</u>	<u>Invoice Date</u>	<u>Non-Allowable Legal Fee</u>	<u>Allowable Legal Fee</u>
Leonard Smith dba ABC Acconts Corp.	9/17/2014	91.00	
Leonard Smith dba ABC Acconts Corp.	1/21/2014	43.00	
Leonard Smith dba ABC Acconts Corp.	4/23/2014	86.00	
Clerk of the Circuit Court	10/7/2013	(177.00)	
Clerk of the Circuit Court	5/14/2014	337.00	
Clerk of the Circuit Court	4/23/2014	6.00	
Clerk of the Circuit Court	3/11/2014	45.00	
Clerk of the Circuit Court	4/8/2014	6.00	
Clerk of the Circuit Court	10/28/2014	337.00	
Clerk of the Circuit Court	3/11/2014	6.00	
Clerk of the Circuit Court	6/30/2014	6.00	
Clerk of the Circuit Court	1/21/2014	6.00	
Markley Investigations Inc.	1/13/2014	50.00	
Markley Investigations Inc.	2/25/2014	50.00	
Markley Investigations Inc.	5/12/2014	50.00	
Recorder of Deeds Cook County	1/21/2014	40.00	
Sheriff of DuPage County	5/14/2014	43.00	
Iake County Sheriff Department (IN)	6/17/2014	60.00	

1,085.00

Vendor Name	Invoice Date	Non-Allowable Legal Fee	Allowable Legal Fee
AMS Corp Legal Cost Alloc-'14	1/31/2014	3,909.00	
AMS Corp Legal Cost Alloc-'14	2/28/2014	3,909.00	
AMS Corp Legal Cost Alloc-'14	3/31/2014	3,909.00	
AMS Corp Legal Cost Alloc-'14	4/30/2014	3,909.00	
AMS Corp Legal Cost Alloc-'14	5/31/2014	3,909.00	
AMS Corp Legal Cost Alloc-'14	6/30/2014	3,909.00	

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

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

Facility Name & ID Number Heather Health Care Center

0023945

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? CNA:Yes RN/LPN:No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Health Care Council of ILL \$9,550
- (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? _____
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,555 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. \$ 364,524
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 30,888 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.