FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0052159

Facility Name: Heights Healthcare And Rehabilitation Centre, Llc

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

County: Peoria

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

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

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,495	914	5,758	31,167	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,495	914	5,758	31,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.63%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2013

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 110 and days of care provided 1,690

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centr # 0052159 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	206,029	36,719	8,155	250,903		250,903	37	250,940			1
2	Food Purchase		169,613		169,613		169,613	(50)	169,563			2
3	Housekeeping	58,054	26,194	92,178	176,426		176,426	728	177,154			3
4	Laundry	23,391	8,065	61,718	93,174		93,174		93,174			4
5	Heat and Other Utilities			94,953	94,953		94,953	(13,260)	81,693			5
6	Maintenance	62,385	12,782	78,669	153,836		153,836	21,865	175,701			6
7	Other (specify):*											7
8	**TOTAL General Services**	349,859	253,373	335,673	938,905		938,905	9,320	948,225			8
	B. Health Care and Programs											
9	Medical Director			14,850	14,850		14,850	199	15,049			9
10	Nursing and Medical Records	1,740,054	81,708	41,652	1,863,414		1,863,414	17,594	1,881,008			10
10a	Therapy	57,828		1,425	59,253		59,253		59,253			10a
11	Activities	68,857	3,610	3,954	76,421		76,421	6	76,427			11
12	Social Services	200,937		3,954	204,891		204,891	3,573	208,464			12
13	CNA Training											13
14	Program Transportation			3,622	3,622		3,622		3,622			14
15	Other (specify):*							5,807	5,807			15
16	**TOTAL Health Care and Programs**	2,067,676	85,318	69,457	2,222,451		2,222,451	27,179	2,249,630			16
	C. General Administration											
17	Administrative	124,501		56,267	180,768		180,768	(38,563)	142,205			17
18	Directors Fees											18
19	Professional Services			214,455	214,455		214,455	(116,046)	98,409			19
20	Dues, Fees, Subscriptions & Promotions			92,103	92,103		92,103	(55,389)	36,714			20
21	Clerical & General Office Expenses	134,231	9,254	302,494	445,979		445,979	(94,136)	351,843			21
22	Employee Benefits & Payroll Taxes			385,532	385,532		385,532	(63)	385,469			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,113	3,113		3,113	35	3,148			24
25	Other Admin. Staff Transportation			13,499	13,499		13,499	1,956	15,455			25
26	Insurance-Prop.Liab.Malpractice			58,624	58,624		58,624	400	59,024			26
27	Other (specify):*							32,943	32,943			27
28	**TOTAL General Administration**	258,732	9,254	1,126,087	1,394,073		1,394,073	(268,862)	1,125,211			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,676,267	347,945	1,531,217	4,555,429		4,555,429	(232,363)	4,323,066			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 Heights Healthcare And Rehabilitation Centre, Llc #0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			111,156	111,156		111,156	219,146	330,302			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,434	8,434		8,434	(5,795)	2,639			32
33	Real Estate Taxes			51,637	51,637		51,637	2,817	54,454			33
34	Rent-Facility & Grounds			466,669	466,669		466,669	(466,669)				34
35	Rent-Equipment & Vehicles			26,691	26,691		26,691	435	27,126			35
36	Other (specify):*											36
37	TOTAL Ownership			664,587	664,587		664,587	(250,066)	414,521			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,900	433,748	586,648		586,648		586,648			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			233,954	233,954		233,954		233,954			42
43	Other (specify):*			39,666	39,666		39,666	(39,666)				43
44	TOTAL Special Cost Centers		152,900	707,368	860,268		860,268	(39,666)	820,602			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,676,267	500,845	2,903,172	6,080,284		6,080,284	(522,095)	5,558,189			45

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,767)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	213,294	30		9
10	Interest and Other Investment Income	(3,736)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(50)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,869)	21		24
25	Fund Raising, Advertising and Promotional	(53,687)	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	(525,375)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (553,439)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	31,344		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 31,344		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (522,095)		37

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

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

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

STATE OF ILLINOIS

Heights Healthcare And Rehabilitation Centre, Llc

ID# 0052159

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Consultant	$ (19,800)	43	1
2	Bank Charges	(7,474)	21	2
3	Marketing Salaries	(19,866)	43	3
4	Theft and Loss	(182)	21	4
5	Sequestration Expense	(17,571)	21	5
6	Non-Allowable Interest	(5,063)	32	6
7	Prior Year Employee Benefits	(63)	22	7
8	Capitalized R&M	(2,620)	06	8
9	Additional R&M	16,632	06	9
10	Non-Allowable Legal	(2,159)	19	10
11	PAC Dues	(540)	20	11
12	Rent for Sale Leaseback Arrangement	(466,669)	34	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(525,375)		49

Heights Healthcare And Rehabilitation Centre, Llc

ID# 0052159

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			37									37	1
2	Food Purchase	(50)											(50)	2
3	Housekeeping			721	7								728	3
4	Laundry													4
5	Heat and Other Utilities	(14,767)		1,281	226								(13,260)	5
6	Maintenance	14,012		7,525	329								21,865	6
7	Other (specify):*													7
8	**TOTAL General Services**	(805)		9,563	562								9,320	8
	B. Health Care and Programs													
9	Medical Director			199									199	9
10	Nursing and Medical Records			17,594									17,594	10
10a	Therapy													10a
11	Activities			6									6	11
12	Social Services			3,573									3,573	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,807									5,807	15
16	**TOTAL Health Care and Programs**			27,179									27,179	16
	C. General Administration													
17	Administrative			17,704		(56,267)							(38,563)	17
18	Directors Fees													18
19	Professional Services	(2,159)		(114,263)	79	297							(116,046)	19
20	Fees, Subscriptions & Promotions	(58,477)		3,084	4								(55,389)	20
21	Clerical & General Office Expenses	(190,096)		95,915	44								(94,136)	21
22	Employee Benefits & Payroll Taxes	(63)											(63)	22
23	Inservice Training & Education													23
24	Travel and Seminar			35									35	24
25	Other Admin. Staff Transportation			273		1,683							1,956	25
26	Insurance-Prop.Liab.Malpractice			252	148								400	26
27	Other (specify):*			32,943									32,943	27
28	**TOTAL General Administration**	(250,795)		35,944	275	(54,287)							(268,862)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(251,599)		72,686	837	(54,287)							(232,363)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc **#** 0052159 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	213,294		4,345	1,507								219,146	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,799)			3,004								(5,795)	32
33	Real Estate Taxes				2,817								2,817	33
34	Rent-Facility & Grounds	(466,669)		6,382	(6,382)								(466,669)	34
35	Rent-Equipment & Vehicles			435									435	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(262,174)		11,162	947								(250,066)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(39,666)											(39,666)	43
44	**TOTAL Special Cost Centers**	(39,666)											(39,666)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(553,439)		83,848	1,784	(54,287)							(522,095)	45

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								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			$			$	$ *	14

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	MOSAIC HEALTHCARE	100.00%	$ 37	$ 37	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	721	721	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	1,281	1,281	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	7,525	7,525	18
19	V	9	MEDICAL DIRECTOR		MOSAIC HEALTHCARE	100.00%	199	199	19
20	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	37,394	37,394	20
21	V	11	ACTIVITIES		MOSAIC HEALTHCARE	100.00%	6	6	21
22	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	3,573	3,573	22
23	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	5,807	5,807	23
24	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	17,704	17,704	24
25	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	(2,063)	(2,063)	25
26	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	3,084	3,084	26
27	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	116,484	116,484	27
28	V	21	CLERICAL AND GENERAL EXP	33,000	MOSAIC HEALTHCARE	100.00%	12,432	(20,568)	28
29	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	35	35	29
30	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	273	273	30
31	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	252	252	31
32	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	32,943	32,943	32
33	V	30	DEPRECIATION		MOSAIC HEALTHCARE	100.00%	4,345	4,345	33
34	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	6,382	6,382	34
35	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	435	435	35
36	V	19	BOOKKEEPING	92,400	MOSAIC HEALTHCARE	100.00%		(92,400)	36
37	V	19	ADMINISTRATIVE CONSULTANT	19,800	MOSAIC HEALTHCARE	100.00%		(19,800)	37
38	V	10	MDS CONSULTANT	19,800	MOSAIC HEALTHCARE	100.00%		(19,800)	38
39	Total			$ 165,000			$ 248,848	$ * 83,848	39

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSKEEPING	$	4600 TOUHY, LLC	100.00%	$ 7	$ 7	15
16	V	5	UTILITIES		4600 TOUHY, LLC	100.00%	226	226	16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	329	329	17
18	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	79	79	18
19	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	4	4	19
20	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	44	44	20
21	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	148	148	21
22	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,507	1,507	22
23	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	3,004	3,004	23
24	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,817	2,817	24
25	V								25
26	V	34	RENT	6,382	4600 TOUHY, LLC	100.00%		(6,382)	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			$ 6,382			$ 8,166	$ * 1,784	39

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	297	$ 297	15
16	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	1,683	1,683	16
17	V	17	MANAGEMENT FEES	56,267	TETRAD MANAGEMENT, LLC	100.00%		(56,267)	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			$ 56,267			$ 1,980	$ * (54,287)	39

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	TETRAD MANAGEMENT	0.01%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	CENTRAL ILLINOIS OPERATIONS, LLC	99.99%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	MOSAIC HC	LINCOLNWOOD	BOOKKEEPING	2
3			MID AMERICA CARE CENTER, L.L.C.	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	3
4			CAPITOL HEALTHCARE & REHABILITATION CTR., LLC	SPRINGFIELD				4
5			COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON				5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS				6
7			MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				7
8			MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				8
9			RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				9
10			MAYFIELD HEALTHCARE AND REHAB CENTER	CHICAGO				10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Cent # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		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 Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	491,775	10	$ 583	$	31,167	$ 37	1
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376		31,167	721	2
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206		31,167	1,281	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728		31,167	7,525	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145		31,167	199	5
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	31,167	37,394	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95		31,167	6	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	31,167	3,573	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625		31,167	5,807	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	31,167	17,704	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)		31,167	(2,063)	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662		31,167	3,084	12
13	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	491,775	10	1,837,959	1,837,959	31,167	116,484	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155		31,167	12,432	14
15	24	SEMINARS	PATIENT DAYS	491,775	10	556		31,167	35	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308		31,167	273	16
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971		31,167	252	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798		31,167	32,943	18
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552		31,167	4,345	19
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10			31,167		20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700		31,167	6,382	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863		31,167	435	22
23										23
24										24
25	TOTALS					$ 3,926,495	$ 2,763,717		$ 248,848	25

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSKEEPING	MNGCR. PATIENT DAYS	491,775	10	$ 107	$	31,167	$ 7	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	491,775	10	3,569		31,167	226	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	491,775	10	5,190		31,167	329	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	491,775	10	1,250		31,167	79	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	491,775	10	63		31,167	4	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	491,775	10	698		31,167	44	6
7	26	INSURANCE	MNGCR. PATIENT DAYS	491,775	10	2,336		31,167	148	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS	491,775	10	23,779		31,167	1,507	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	491,775	10	47,406		31,167	3,004	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	491,775	10	44,453		31,167	2,817	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,850	$		$ 8,166	25

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682		31,167	297	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559		31,167	1,683	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 31,241	$		$ 1,980	25

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centr # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from 4600 Touhy, LLC		X								3,004	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 3,004	9
	B. Non-Facility Related*											
10	Interest Income		X								(365)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (365)	14
15	TOTALS (line 9+line14)						$	$			$ 2,640	15

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centr # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc **#** 0052159 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 56,430	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.)		$ 53,441	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,989)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 57,443	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.		$ 54,454	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011		9
2012	53,020	10
2013	50,950	11
2014	50,624	12

2015 Accrual = 2014 Accrual $56,430 + ($50,624 * 2% = $1,012) = $57,443

Allocated from 4600 Touhy, LLC - $2,817

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heights Healthcare And Rehabilitation Centre, Llc COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052159

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	Long Term Care Property	$ 50,624.10	$ 50,624.10
2.	See Attached	Allocated From 4600 Touhy. LLC	$ 86,316.15	$ 2,735.21
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 136,940.25	$ 53,359.31

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heights Healthcare And Rehabilitation Centre, Llc COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052159

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	400,860	2013	$ 290,419	1
2	Allocated from 4600 Touhy			5,704	2
3	TOTALS	400,860		$ 296,123	3

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		2013	1977	$ 4,564,608	$	35	$ 130,417	$ 130,417	$ 253,845	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		66,443	1,911		2,780	869	10,787	68
69	Financial Statement Depreciation			111,156			(111,156)		69
70	TOTAL (lines 4 thru 69)		$ 4,631,051	$ 113,067		$ 133,197	$ 20,130	$ 264,632	70

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,631,051	$ 113,067		$ 133,197	$ 20,130	$ 264,632	1
2	Mop Sink Faucet And Valve	2013	4,119		20	275	275	778	2
3	Replace Circuit Control Board & Power Supply	2013	5,545		20	277	277	647	3
4	Window Treatments	2013	63,058		20	12,612	12,612	28,376	4
5	Design Services For Building Renovation Project	2013	13,000		20	2,600	2,600	5,850	5
6	Install Light Fixtures In Corridor, Therapy Room, Resident Room	2013	26,062		20	1,303	1,303	2,715	6
7	Installed 12 Drop Sinks & Level Faucets & New Laminate Vanity	2013	8,271		20	414	414	862	7
8	Remove Carpet, Vinyl Floor, Rails, Counter Tops, Closets, Windo	2013	44,365		20	2,218	2,218	4,621	8
9	Install Floor In Corridor, Dining, Nurse Station, Lobby, Therapy,	2013	77,993		20	3,900	3,900	8,124	9
10	Install New Drywall In Therapy Rm, Installed Double Door & Wi	2013	17,680		20	884	884	1,842	10
11	Install Vanity Tops With Drop Sink, Door Kick Plates, And Corne	2013	50,656		20	2,533	2,533	5,277	11
12	Paint Drywall Ceilings, Acoustical Ceilings, Doors & Frames, Inte	2013	25,772		20	1,289	1,289	2,685	12
13	Install Sprinklers To Side Of Existing Sprinkler Lines,Relocate Cl	2013	7,292		20	365	365	760	13
14	Electrical, Plumbing & Flooring For Resident Rooms, Bathrooms,	2013	24,154		20	1,208	1,208	2,516	14
15	Asphalt Parking Lot	2013	46,413		20	2,321	2,321	5,415	15
16	Sprinkler Installation	2013	98,800		20	4,900	4,900	10,208	16
17	Laminate Counter Top	2014	6,190		20	1,238	1,238	1,341	17
18	Cable And Tv Wiring	2014	11,986		20	2,397	2,397	4,794	18
19	Replace Heat Exchanger On Roof Top Unit	2014	4,295		20	215	215	251	19
20	Installed Door Security Control Equipment	2014	3,290		20	165	165	329	20
21	Installed New Fire Door & Dampers	2014	4,943		20	247	247	371	21
22	New Exit & Rm Number Signs, Window Treatments In Front Offi	2014	18,192		20	910	910	1,819	22
23	Wall Cut And Install Ptac Units In Therapy Room	2015	6,842		20	314	314	314	23
24	Wire/Conduit Work - Installation Of 2 Outlets	2015	3,958		20	132	132	132	24
25	Installation Of 2 30Amp Power Dees For New Ac/Heat Units	2015	4,251		20	142	142	142	25
26	Furnished And Installed New Storage Tank	2015	3,667		20	244	244	244	26
27	Concrete Work For Back Patio	2015	4,287		20	224	224	224	27
28	Control Circuit - Replace Horn At Nurse Call Station	2015	2,620		20	131	131	131	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,218,751	$ 113,067		$ 176,652	$ 63,585	$ 355,398	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,218,751	$ 113,067		$ 176,652	$ 63,585	$ 355,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,218,751	$ 113,067		$ 176,652	$ 63,585	$ 355,398	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,218,751	$ 113,067		$ 176,652	$ 63,585	$ 355,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,218,751	$ 113,067		$ 176,652	$ 63,585	$ 355,398	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,218,751	$ 113,067		$ 176,652	$ 63,585	$ 355,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,218,751	$ 113,067		$ 176,652	$ 63,585	$ 355,398	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4	Allocated from 4600 Touhy, LLC	2012	32,541	834	30	1,085	251	4,339	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Mosaic HC	2013	546	105	20	27	(78)	82	10
11	Allocated from Mosaic HC	2012	6,794	299	20	340	41	1,359	11
12									12
13									13
14	Allocated from 4600 Touhy, LLC	2012	20,956	540	20	1,048	508	4,191	14
15	Allocated from 4600 Touhy, LLC	2013	5,099	120	20	255	135	765	15
16	Allocated from 4600 Touhy, LLC	2014	507	13	20	25	12	51	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 66,443	$ 1,911		$ 2,780	$ 869	$ 10,787	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 66,443	$ 1,911		$ 2,780	$ 869	$ 10,787	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 66,443	$ 1,911		$ 2,780	$ 869	$ 10,787	34

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,231,763	$ 3,727	$ 145,299	$ 141,572	10	$ 396,647	71
72	Current Year Purchases	51,580		8,351	8,351	10	8,351	72
73	Fully Depreciated Assets	15,839				10	15,839	73
74								74
75	TOTALS	$ 1,299,181	$ 3,727	$ 153,650	$ 149,923		$ 420,837	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Mosaic HC	2015	$ 6,020	$ 214	$	$ (214)	5	$ 6,020	76
77										77
78										78
79										79
80	TOTALS			$ 6,020	$ 214	$	$ (214)		$ 6,020	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)	$ 6,820,075	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,008	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 330,302	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 213,294	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 782,255	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 Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ARC Healthcare II Operating Partnership (Sale Leaseback arrangeemnt)
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. [X] 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:		110		$ 466,669			3
4	Additions							4
5					(466,669)			5
6								6
7	TOTAL		110		$ (0) **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 12,726 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2013 Ford	$ 1,140.00	$ 14,400	17
18					18
19					19
20					20
21	TOTAL		$ 1,140.00	$ 14,400	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 Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 164,245	$		$ 164,245	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			20,949			20,949	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			205,219			205,219	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				126,244		126,244	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					43,335	26,656		69,991	13
14	TOTAL			$		$ 433,748	$ 152,900		$ 586,648	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.

STATE OF ILLINOIS

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 63,067	$	1
2	Cash-Patient Deposits	11,462		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,404,474		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,688		6
7	Other Prepaid Expenses	29,078		7
8	Accounts Receivable (owners or related parties)	70,100		8
9	Other(specify):	20,195		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,605,064	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	347,904		15
16	Equipment, at Historical Cost	425,003		16
17	Accumulated Depreciation (book methods)	(226,772)		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):	176,145		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 722,280	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,327,344	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 787,906	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,462		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,882		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,782		31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,443		32
33	Accrued Interest Payable	1,711		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,549,744		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,536,930	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,536,930	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,209,586)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,327,344	$	48

***(See instructions.)**

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 162,290	1
2	Restatements (describe):		2
3	**Bad Debt Adjustment/Medicare Settlement Income**	(739,770)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (577,480)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(910,668)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	278,562	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)**	$ (632,106)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,209,586)	24 *

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,494,691	1
2	Discounts and Allowances for all Levels	(1,363,030)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,131,661	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	889,540	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 889,540	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	111,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,545	19
20	Radiology and X-Ray	2,285	20
21	Other Medical Services	955	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 142,986	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,736	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,736	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,693	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,693	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,169,616	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	938,905	31
32	Health Care	2,222,451	32
33	General Administration	1,394,073	33
	B. Capital Expense		
34	Ownership	664,587	34
	C. Ancillary Expense		
35	Special Cost Centers	626,314	35
36	Provider Participation Fee	233,954	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,080,284	40
41	**Income before Income Taxes (line 30 minus line 40)****	(910,668)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (910,668)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,904,931	44
45	Private Pay - Net Inpatient Revenue	227,796	45
46	Medicare - Net Inpatient Revenue	376,796	46
47	Other-(specify) Hospice	331,010	47
48	Other-(specify) Insurance	291,128	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,131,661	49

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

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

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,180	2,320	$ 77,804	$ 33.54	1
2	Assistant Director of Nursing	1,840	2,080	68,047	32.71	2
3	Registered Nurses	8,701	9,418	254,909	27.07	3
4	Licensed Practical Nurses	21,427	23,736	569,601	24.00	4
5	CNAs & Orderlies	53,250	58,858	752,366	12.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,868	2,286	57,828	25.30	8
9	Activity Director	1,080	1,120	17,877	15.96	9
10	Activity Assistants	4,395	4,729	50,980	10.78	10
11	Social Service Workers	6,681	7,320	153,024	20.90	11
12	Dietician					12
13	Food Service Supervisor	3,719	4,135	59,364	14.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,882	15,250	146,665	9.62	15
16	Dishwashers					16
17	Maintenance Workers	2,720	2,997	62,385	20.82	17
18	Housekeepers	5,519	6,120	58,054	9.49	18
19	Laundry	2,133	2,387	23,391	9.80	19
20	Administrator	1,875	2,062	124,501	60.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,916	8,713	134,231	15.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,188	1,217	17,327	14.24	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,510	3,756	47,913	12.76	33
34	TOTAL (lines 1 - 33)	143,884	158,504	$ 2,676,267 *	$ 16.88	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 8,155	01-03	35
36	Medical Director	Monthly	14,850	09-03	36
37	Medical Records Consultant	Quarterly	1,920	10-03	37
38	Nurse Consultant	Monthly	33,000	10-03	38
39	Pharmacist Consultant	Monthly	6,732	10-03	39
40	Physical Therapy Consultant	Visit	1,315	10a-03	40
41	Occupational Therapy Consultant	Visit	90	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Visit	20	10a-03	43
44	Activity Consultant	61	3,954	11-03	44
45	Social Service Consultant	61	3,954	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	$ 73,990		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rebecca Newble	Administrator	0	$ 113,812
Heather Obrien	Administrator	0	10,689
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 124,501

B. Administrative - Other

Description	Amount
Management Fees - Tetrad	$ 56,267
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 56,267

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 13,993
Personnel Planners	Unemployment Consulting	9,197
Frost/Marcum	Accounting	18,780
Mosaic HC	Bookkeeping	92,400
Mosaic HC	Administrative Consulting	19,800
Onwards Consulting	IT Consulting	1,608
Achieve Accreditation	Accreditation Services	18,630
Ability Network	Billing Software	4,741
Smartlinx Solutions	Workforce Management	2,329
Galaxy Hosted Software	Clinical and Financial Software	1,672
HealthMEDX	EMR Software	18,383
See Supplemental Schedule		12,922
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 214,455

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,735
Unemployment Compensation Insurance	71,998
FICA Taxes	204,649
Employee Health Insurance	41,419
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	18,141
Safe Harbor Match Expense	18,528
TOTAL (agree to Schedule V, line 22, col.8)	$ 385,469

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,311
Health Care Worker Background Check	2,972
(Indicate # of checks performed 297)	
Patient Background Checks	
Dues and Subscriptions	12,162
Licenses and Permits	3,181
Allocated from Mosaic HC	3,084
Allocated from 4600 Touhy, LLC	4
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,714

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,113
Allocated from Mosaic HC	35
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,148

**See instructions.

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $11,485**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,922** 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? **Yes**
If YES, give effective date of lease. **12/31/14**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **233,954**
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. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

(19) 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.