FOR BHF USE

LL1

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

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

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: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(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: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 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	40,260	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	40,260	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	24,404	2,348	5,853	32,605	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,404	2,348	5,853	32,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.99%

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 2,917

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

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centr # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	219,174	38,623	7,356	265,153		265,153	42	265,195			1
2	Food Purchase		168,155		168,155		168,155	(121)	168,034			2
3	Housekeeping		13,474	187,996	201,470		201,470	556	202,026			3
4	Laundry		5,320	124,342	129,662		129,662		129,662			4
5	Heat and Other Utilities			87,112	87,112		87,112	(12,731)	74,381			5
6	Maintenance	62,427	8,685	79,059	150,171		150,171	(13,645)	136,526			6
7	Other (specify):*											7
8	TOTAL General Services	281,601	234,257	485,865	1,001,723		1,001,723	(25,899)	975,824			8
	B. Health Care and Programs											
9	Medical Director			15,500	15,500		15,500		15,500			9
10	Nursing and Medical Records	1,679,403	109,071	123,910	1,912,384		1,912,384	19,356	1,931,740			10
10a	Therapy	61,030		1,078	62,108		62,108		62,108			10a
11	Activities	65,530	5,047	3,601	74,178		74,178		74,178			11
12	Social Services	159,505		1,974	161,479		161,479	3,688	165,167			12
13	CNA Training											13
14	Program Transportation			1,522	1,522		1,522		1,522			14
15	Other (specify):*							8,433	8,433			15
16	TOTAL Health Care and Programs	1,965,468	114,118	147,585	2,227,171		2,227,171	31,477	2,258,648			16
	C. General Administration											
17	Administrative	145,191		94,522	239,713		239,713	(55,727)	183,986			17
18	Directors Fees											18
19	Professional Services			311,728	311,728		311,728	(188,027)	123,701			19
20	Dues, Fees, Subscriptions & Promotions			59,520	59,520		59,520	(31,393)	28,127			20
21	Clerical & General Office Expenses	124,555	12,901	318,485	455,941		455,941	(146,469)	309,472			21
22	Employee Benefits & Payroll Taxes			382,574	382,574		382,574		382,574			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,040	4,040		4,040	463	4,503			24
25	Other Admin. Staff Transportation			9,516	9,516		9,516	2,813	12,329			25
26	Insurance-Prop.Liab.Malpractice			83,697	83,697		83,697	607	84,304			26
27	Other (specify):*							29,026	29,026			27
28	TOTAL General Administration	269,746	12,901	1,264,082	1,546,729		1,546,729	(388,709)	1,158,020			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,516,815	361,276	1,897,532	4,775,623		4,775,623	(383,131)	4,392,492			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: 01/01/16 Ending: 12/31/16

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	223,729	334,885			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(0)	(0)			32
33	Real Estate Taxes			42,435	42,435		42,435	3,138	45,573			33
34	Rent-Facility & Grounds			388,100	388,100		388,100	(386,643)	1,457			34
35	Rent-Equipment & Vehicles			25,579	25,579		25,579	344	25,923			35
36	Other (specify):*											36
37	TOTAL Ownership			567,270	567,270		567,270	(159,432)	407,838			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,529	522,553	666,082		666,082		666,082			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,413	228,413		228,413		228,413			42
43	Other (specify):*			38,223	38,223		38,223	(38,223)				43
44	TOTAL Special Cost Centers		143,529	789,189	932,718		932,718	(38,223)	894,495			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,516,815	504,805	3,253,991	6,275,611		6,275,611	(580,786)	5,694,825			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: 01/01/16 Ending: 12/31/16

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	(13,909)	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	222,124	30		9
10	Interest and Other Investment Income	(2,930)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(121)	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	(200)	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	(204,084)	21		24
25	Fund Raising, Advertising and Promotional	(26,789)	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	(587,333)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (613,242)		$	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)	32,456		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 32,456		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (580,786)		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: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (6,397)	21	1
2	Marketing Salaries	(18,423)	43	2
3	Late Fees	(10,163)	21	3
4	Theft and Loss	(377)	21	4
5	Medicare Sequestration	(19,186)	21	5
6	Other Taxes	(39)	21	6
7	Rent for Sale Leaseback Arrangement	(388,100)	34	7
8	Marketing Consultant	(19,800)	43	8
9	Capitalized R&M	(15,609)	06	9
10	PAC Dues	(4,691)	20	10
11	Non-allowable legal	(9,340)	19	11
12	Prior period Adj	(500)	21	12
13	Medical Record Income	(23)	10	13
14	Non-allowable Seminar	(163)	24	14
15	Non allowable Management	(94,522)	17	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**	(587,333)		49

Heights Healthcare And Rehabilitation Centre, Llc

ID# 0052159

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			42									42	1
2	Food Purchase	(121)											(121)	2
3	Housekeeping			556									556	3
4	Laundry													4
5	Heat and Other Utilities	(13,909)		975	203								(12,731)	5
6	Maintenance	(15,609)		1,227	542	195							(13,645)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(29,639)		2,800	745	195							(25,899)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(23)		19,379									19,356	10
10a	Therapy													10a
11	Activities													11
12	Social Services			3,688									3,688	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			8,433									8,433	15
16	**TOTAL Health Care and Programs**	(23)		31,500									31,477	16
	C. General Administration													
17	Administrative	(94,522)		38,795									(55,727)	17
18	Directors Fees													18
19	Professional Services	(9,340)		(65,349)	78	(113,416)							(188,027)	19
20	Fees, Subscriptions & Promotions	(31,680)		267	20								(31,393)	20
21	Clerical & General Office Expenses	(240,746)		49,744	14	44,518							(146,469)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(163)		127		499							463	24
25	Other Admin. Staff Transportation			378		2,435							2,813	25
26	Insurance-Prop.Liab.Malpractice			307	131	169							607	26
27	Other (specify):*			21,550		7,476							29,026	27
28	**TOTAL General Administration**	(376,451)		45,819	242	(58,319)							(388,709)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(406,113)		80,118	988	(58,124)							(383,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	222,124			1,605								223,729	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,930)			2,930								(0)	32
33	Real Estate Taxes				3,138								3,138	33
34	Rent-Facility & Grounds	(388,100)		10,578	(10,578)	1,458							(386,643)	34
35	Rent-Equipment & Vehicles			344									344	35
36	Other (specify):*													36
37	TOTAL Ownership	(168,906)		10,922	(2,906)	1,458							(159,432)	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):*	(38,223)											(38,223)	43
44	TOTAL Special Cost Centers	(38,223)											(38,223)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(613,242)		91,040	(1,918)	(56,666)							(580,786)	45

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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%	$ 42	$ 42	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	556	556	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	975	975	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	1,227	1,227	18
19	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	39,179	39,179	19
20	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	3,688	3,688	20
21	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	8,433	8,433	21
22	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	38,795	38,795	22
23	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	1,201	1,201	23
24	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	267	267	24
25	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	70,751	70,751	25
26	V	21	CLERICAL AND GENERAL EXP		MOSAIC HEALTHCARE	100.00%	8,693	8,693	26
27	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	127	127	27
28	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	378	378	28
29	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	307	307	29
30	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	21,550	21,550	30
31	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	10,578	10,578	31
32	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	344	344	32
33	V	19	BOOKKEEPING	46,750	MOSAIC HEALTHCARE	100.00%		(46,750)	33
34	V	10	MDS CONSULTANT	19,800	MOSAIC HEALTHCARE	100.00%		(19,800)	34
35	V	19	ADMINISTRATIVE	19,800	MOSAIC HEALTHCARE	100.00%		(19,800)	35
36	V	21	OFFICE CONSULTANT	29,700	MOSAIC HEALTHCARE	100.00%		(29,700)	36
37	V								37
38	V								38
39	Total			$ 116,050			$ 207,090	$ * 91,040	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES		4600 TOUHY, LLC	100.00%	203	$ 203	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	542	542	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	78	78	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	20	20	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	14	14	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	131	131	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,605	1,605	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,930	2,930	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	3,138	3,138	23
24	V								24
25	V	34	RENT	10,578	4600 TOUHY, LLC	100.00%		(10,578)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,578			$ 8,660	$ * (1,918)	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: 01/01/16 Ending: 12/31/16

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	6	MAINTENANCE & REPAIR	$	PLATINUM BILLING SOLUTIONS	30.00%	$ 195	$ 195	15
16	V	19	PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	1,030	1,030	16
17	V	21	CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	6,890	6,890	17
18	V	21	CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	37,629	37,629	18
19	V	24	BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	499	499	19
20	V	25	AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	2,435	2,435	20
21	V	26	INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	169	169	21
22	V	27	EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	7,476	7,476	22
23	V	34	RENT		PLATINUM BILLING SOLUTIONS	30.00%	1,458	1,458	23
24	V	19	BOOKKEEPING	114,446	PLATINUM BILLING SOLUTIONS	30.00%		(114,446)	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			$ 114,446			$ 57,780	$ * (56,666)	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	TETRAD MANAGEMENT	0.01%	MOSAIC OF BEACON	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	CENTRAL ILLINOIS OPERATIONS, LLC	99.99%	MOSAIC OF LAKE SHORE	CHICAGO	MOSAIC HC	LINCOLNWOOD	BOOKKEEPING	2
3			MOSAIC OF UPTOWN	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	3
4			MOSAIC OF SPRINGFIELD	SPRINGFIELD	PLATINUM BILLING SOLUTION	LAKEWOOD, NJ	AR MANAGEMENT SERVICI	4
5			COLONIAL HEALTHCARE & REHABILITATION CTR.	PRINCETON	Worthy Insurance Group, LLC	Skokie	Insurance Company	5
6			MORTON TERRACE HEALTHCARE & REHAB CTR.	MORTON				6
7			MORTON VILLA HEALTHCARE & REHABILITATION CTR.	MORTON				7
8			RIVERSHORES HEALTHCARE & REHABILITATION CTR.	MARSEILLES				8
9			MOSAIC OF MAYFIELD	CHICAGO				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 Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	483,176	10	$ 625	$	32,605	$ 42	1
2	3	HOUSEKEEPING	PATIENT DAYS	483,176	10	8,235		32,605	556	2
3	5	UTILITIES	PATIENT DAYS	483,176	10	14,454		32,605	975	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	483,176	10	18,179		32,605	1,227	4
5	10	NURSING SALARIES	PATIENT DAYS	483,176	10	580,592	580,592	32,605	39,179	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	483,176	10	54,655	54,655	32,605	3,688	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	483,176	10	124,964		32,605	8,433	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	483,176	10	574,906	574,906	32,605	38,795	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	483,176	10	17,800		32,605	1,201	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	483,176	10	3,962		32,605	267	10
11	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	483,176	10	1,048,463	1,048,463	32,605	70,751	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	483,176	10	128,829		32,605	8,693	12
13	24	SEMINARS	PATIENT DAYS	483,176	10	1,876		32,605	127	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	483,176	10	5,603		32,605	378	14
15	26	INSURANCE	PATIENT DAYS	483,176	10	4,543		32,605	307	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	483,176	10	319,345		32,605	21,550	16
17	34	RENT - BUILDING (RELATED)	PATIENT DAYS	483,176	10	156,750		32,605	10,578	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	483,176	10	5,104		32,605	344	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,068,885	$ 2,258,616		$ 207,090	25

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	483,176	10	3,010		32,605	203	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	483,176	10	8,036		32,605	542	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	483,176	10	1,150		32,605	78	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	483,176	10	293		32,605	20	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	483,176	10	209		32,605	14	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	483,176	10	1,941		32,605	131	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	483,176	10	23,779		32,605	1,605	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	483,176	10	43,419		32,605	2,930	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	483,176	10	46,499		32,605	3,138	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,334	$		$ 8,660	25

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PLATINUM BILLING SOLUTIONS
Street Address: 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code: LAKEWOOD, NJ 08701
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	6	MAINTENANCE & REPAIR	PATIENT DAYS	483,176	10	$ 2,885	$	32,605	$ 195	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	483,176	10	15,260		32,605	1,030	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	483,176	10	102,097		32,605	6,890	3
4	21	CLERICAL & GENERAL- SALA	PATIENT DAYS	483,176	10	557,621	557,621	32,605	37,629	4
5	24	BUSINESS SEMINAR	PATIENT DAYS	483,176	10	7,400		32,605	499	5
6	25	AUTO & TRAVEL	PATIENT DAYS	483,176	10	36,080		32,605	2,435	6
7	26	INSURANCE	PATIENT DAYS	483,176	10	2,507		32,605	169	7
8	27	EMPLOYEE BENEFITS/TAXES	PATIENT DAYS	483,176	10	110,789		32,605	7,476	8
9	34	RENT	PATIENT DAYS	483,176	10	21,600		32,605	1,458	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					$ 856,240	$ 557,621		$ 57,780	25

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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
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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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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
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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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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
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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: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Allocated from 4600 Touhy, LLC		X								2,930	6
7												7
8					-							8
9	TOTAL Facility Related						$	$			$ 2,930	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,930)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (2,930)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 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: 01/01/16 Ending: 12/31/16

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** 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
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:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 24,036	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.)		$ 44,741	2
3. Under or (over) accrual (line 2 minus line 1).		$ 20,705	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 24,868	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.		$ 45,573	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012	53,020	9
2013	50,950	10
2014	50,624	11
2015	41,603	12

2016 Accrual = $41,603 X 60% = $24,868 (Rounded)

Adjusted 2015 beginning accrual by $33,407 as the RE Tax expense was understated

Allocated from 4600 Touhy, LLC - $3,138

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	Long Term Care Property	$ 41,603.30	$ 41,603.30
2.	See Attached	Allocated From 4600 Touhy. LLC	$ 89,919.35	$ 3,033.91
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 131,522.65	$ 44,637.21

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 LLC			6,073	2
3	TOTALS	400,860		$ 296,492	3

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 384,262	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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)		70,745	1,605		2,960	1,355	14,445	68
69	Financial Statement Depreciation			111,156			(111,156)		69
70	TOTAL (lines 4 thru 69)		$ 4,635,353	$ 112,761		$ 133,377	$ 20,616	$ 398,707	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 4,635,353	$ 112,761		$ 133,377	$ 20,616	$ 398,707	1
2	Mop Sink Faucet And Valve	2013	4,119		20	275	275	1,053	2
3	Replace Circuit Control Board & Power Supply	2013	5,545		20	277	277	924	3
4	Window Treatments	2013	63,058		20	12,612	12,612	40,987	4
5	Design Services For Building Renovation Project	2013	13,000		20	2,600	2,600	8,450	5
6	Install Light Fixtures In Corridor, Therapy Room, Resident Room	2013	26,062		20	1,303	1,303	4,018	6
7	Installed 12 Drop Sinks & Level Faucets & New Laminate Vanity	2013	8,271		20	414	414	1,275	7
8	Remove Carpet, Vinyl Floor, Rails, Counter Tops, Closets, Windo	2013	44,365		20	2,218	2,218	6,840	8
9	Install Floor In Corridor, Dining, Nurse Station, Lobby, Therapy,	2013	77,993		20	3,900	3,900	12,024	9
10	Install New Drywall In Therapy Rm, Installed Double Door & Wi	2013	17,680		20	884	884	2,726	10
11	Install Vanity Tops With Drop Sink, Door Kick Plates, And Corne	2013	50,656		20	2,533	2,533	7,809	11
12	Paint Drywall Ceilings, Acoustical Ceilings, Doors & Frames, Inte	2013	25,772		20	1,289	1,289	3,973	12
13	Install Sprinklers To Side Of Existing Sprinkler Lines,Relocate Cl	2013	7,292		20	365	365	1,124	13
14	Electrical, Plumbing & Flooring For Resident Rooms, Bathrooms,	2013	24,154		20	1,208	1,208	3,724	14
15	Asphalt Parking Lot	2013	46,413		20	2,321	2,321	7,736	15
16	Sprinkler Installation	2013	98,800		20	4,940	4,940	15,232	16
17	Laminate Counter Top	2014	6,190		20	1,238	1,238	2,579	17
18	Cable And Tv Wiring	2014	11,986		20	2,397	2,397	7,192	18
19	Replace Heat Exchanger On Roof Top Unit	2014	4,295		20	215	215	465	19
20	Installed Door Security Control Equipment	2014	3,290		20	165	165	494	20
21	Installed New Fire Door & Dampers	2014	4,943		20	247	247	618	21
22	New Exit & Rm Number Signs, Window Treatments In Front Offi	2014	18,192		20	910	910	2,729	22
23	Wall Cut And Install Ptac Units In Therapy Room	2015	6,842		20	342	342	656	23
24	Concrete Work For Back Patio	2015	4,287		20	214	214	322	24
25	Wire/Conduit Work - Installation Of 2 Outlets	2015	3,958		20	264	264	396	25
26	Installation Of 2 30Amp Power Dees For New Ac/Heat Units	2015	4,251		20	284	284	425	26
27	Furnished And Installed New Storage Tank	2015	3,667		20	183	183	244	27
28	Control Circuit - Replace Horn At Nurse Call Station	2015	2,620		20	131	131	196	28
29	Installation Of Heated Bath Fans	2016	3,432		20	172	172	172	29
30	Pave The Parking Lot Driveway With Gravel	2016	8,850		20	443	443	443	30
31	Replaced Boiler Pump And Switch	2016	2,567		20	128	128	128	31
32	Fire Alarm Parts Replacement	2016	2,690		20	135	135	135	32
33	Replace Motor And Blower Wheel	2016	2,802		20	140	140	140	33
34	TOTAL (lines 1 thru 33)		$ 5,243,394	$ 112,761		$ 178,120	$ 65,359	$ 533,934	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 5,243,394	$ 112,761		$ 178,120	$ 65,359	$ 533,934	1
2	Install Gfci In Med Room	2016	3,265		20	163	163	163	2
3	Interior And Exterior For Radon Removal System	2016	4,285		20	214	214	214	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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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)		$ 5,250,944	$ 112,761		$ 178,497	$ 65,736	$ 534,311	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 5,250,944	$ 112,761		$ 178,497	$ 65,736	$ 534,311	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)		$ 5,250,944	$ 112,761		$ 178,497	$ 65,736	$ 534,311	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 5,250,944	$ 112,761		$ 178,497	$ 65,736	$ 534,311	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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19									19
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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)		$ 5,250,944	$ 112,761		$ 178,497	$ 65,736	$ 534,311	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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									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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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
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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)		$	$		$	$	$	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	34,648	888	30	1,155	267	5,775	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from 4600 Touhy, LLC	2012	22,313	575	20	1,116	541	5,578	10
11	Allocated from 4600 Touhy, LLC	2013	5,429	128	20	271	143	1,086	11
12	Allocated from 4600 Touhy, LLC	2014	539	14	20	27	13	81	12
13									13
14	Allocated from Mosaic Healthcare	2013	582		20	29	29	116	14
15	Allocated from Mosaic Healthcare	2012	7,234		20	362	362	1,809	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)		$ 70,745	$ 1,605		$ 2,960	$ 1,355	$ 14,445	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 70,745	$ 1,605		$ 2,960	$ 1,355	$ 14,445	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 70,745	$ 1,605		$ 2,960	$ 1,355	$ 14,445	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: 01/01/16 Ending: 12/31/16

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	$ 1,284,413	$	$ 156,388	$ 156,388	10	$ 561,839	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	17,330				10	17,330	73
74								74
75	TOTALS	$ 1,301,743	$	$ 156,388	$ 156,388		$ 579,169	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	$ 6,410	$	$	$	5	$ 6,410	76
77										77
78										78
79										79
80	TOTALS			$ 6,410	$	$	$		$ 6,410	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)	$ 6,855,590	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 112,761	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 334,885	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 222,124	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,119,890	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: 01/01/16 Ending: 12/31/16

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		$ 388,100			3
4	Additions				(388,100)			4
5	Allocated from Platinum				1,458			5
6								6
7	TOTAL		110		$ 1,458 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 9,854 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	$ 1,200	$ 16,069	17
18					18
19					19
20					20
21	TOTAL		$ 1,200	$ 16,069	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 219,674	$		$ 219,674	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,060			36,060	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			206,441			206,441	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				126,097		126,097	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					60,378	17,432		77,810	13
14	TOTAL			$		$ 522,553	$ 143,529		$ 666,082	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:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 51,736	$	1
2	Cash-Patient Deposits	8,212		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,174,784		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,534		6
7	Other Prepaid Expenses	10,997		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	58,702		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,352,965	$	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	369,037		15
16	Equipment, at Historical Cost	427,362		16
17	Accumulated Depreciation (book methods)	(331,027)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	753,045		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,218,417	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,571,382	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 675,085	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,212		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,467		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,404		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,868		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	16,198		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 971,234	$	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	See Attached Schedule	3,335,808		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,335,808	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,307,042	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,735,660)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,571,382	$	48

***(See instructions.)**

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,209,586)	1
2	Restatements (describe):		2
3	**Contributions from prior year**	(284,027)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,493,613)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(865,609)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	623,562	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)**	$ (242,047)	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)**	$ (1,735,660)	24 *

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

Facility Name & ID Number Heights Healthcare And Rehabilitation Centre, Llc # 0052159 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 5,317,666	1
2	Discounts and Allowances for all Levels	(891,895)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,425,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	835,155	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 835,155	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	125,372	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,955	19
20	Radiology and X-Ray	2,235	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 145,562	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,514	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,514	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,410,002	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,001,723	31
32	Health Care	2,227,171	32
33	General Administration	1,546,729	33
	B. Capital Expense		
34	Ownership	567,270	34
	C. Ancillary Expense		
35	Special Cost Centers	704,305	35
36	Provider Participation Fee	228,413	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,275,611	40
41	**Income before Income Taxes (line 30 minus line 40)****	(865,609)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (865,609)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,843,338	44
45	Private Pay - Net Inpatient Revenue	332,417	45
46	Medicare - Net Inpatient Revenue	724,468	46
47	Other-(specify) Managed Care / Hospice	1,470,522	47
48	Other-(specify) RT/Services Insurance	55,026	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,425,771	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.**

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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	2,012	2,340	$ 84,481	$ 36.10	1
2	Assistant Director of Nursing	1,169	1,314	41,671	31.71	2
3	Registered Nurses	7,489	8,057	251,214	31.18	3
4	Licensed Practical Nurses	19,521	21,332	523,547	24.54	4
5	CNAs & Orderlies	49,098	53,596	739,400	13.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,871	2,361	61,030	25.85	8
9	Activity Director	219	219	3,499	15.98	9
10	Activity Assistants	5,056	5,456	62,031	11.37	10
11	Social Service Workers	5,892	6,448	120,505	18.69	11
12	Dietician					12
13	Food Service Supervisor	3,433	3,684	61,694	16.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,012	15,399	157,480	10.23	15
16	Dishwashers					16
17	Maintenance Workers	3,186	3,512	62,427	17.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,528	2,702	145,191	53.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,004	7,754	124,555	16.06	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	2,746	2,822	39,090	13.85	31
32	Other Health Care(specify)					32
33	Other(specify)	2,712	2,976	39,000	13.10	33
34	TOTAL (lines 1 - 33)	127,948	139,972	$ 2,516,815 *	$ 17.98	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	130	$ 7,356	01-03	35
36	Medical Director	Monthly	15,500	09-03	36
37	Medical Records Consultant	Quarterly	1,530	10-03	37
38	Nurse Consultant	Monthly	39,600	10-03	38
39	Pharmacist Consultant	Monthly	7,169	10-03	39
40	Physical Therapy Consultant	Visit	718	10a-03	40
41	Occupational Therapy Consultant	Visit	292	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Visit	68	10a-03	43
44	Activity Consultant	56	3,601	11-03	44
45	Social Service Consultant	30	1,974	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	216	$ 77,808		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	3,024	75,611	10-03	52
53	TOTAL (lines 50 - 52)	3,024	$ 75,611		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rebecca Newble	Administrator	0	$ 92,834
Heather Obrien	Administrator	0	52,357
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 145,191

B. Administrative - Other

Description	Amount
Management Fees- Tetrad	$ 94,522
TOTAL (agree to Schedule V, line 17, col. 3)	$ 94,522
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached	Legal	$ 13,437
Personnel Planners	Unemployment Consulting	675
Marcum	Accounting	23,182
Mosaic HC	Bookkeeping	46,750
Mosaic HC	Administrative Consulting	19,800
Achieve Accreditation	Accreditation Services	18,499
Creative Technology Solutions	IT Consulting	21,381
Compu Solutions	IT Consulting	1,600
Ability Network	Billing Software	8,605
E One Solutions LLC	ERP Software	79
Galaxy Hosted Software	Clinical and Financial Software	1,460
See Supplemental Schedule		156,260
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 311,728

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,862
Unemployment Compensation Insurance	69,819
FICA Taxes	181,069
Employee Health Insurance	53,349
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	27,171
401K Match Expense	15,304
TOTAL (agree to Schedule V, line 22, col.8)	$ 382,574

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,508
Health Care Worker Background Check	3,006
(Indicate # of checks performed 300)	
Patient Background Checks	
Dues and Subscriptions	11,472
Licenses and Permits	5,854
Allocated from Mosaic HC	267
Allocated from 4600 Touhy, LLC	20
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,877
Allocated from Mosaic HC	127
Allocated from Platinum Billing	499
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,503

* Attach copy of IMRF notifications

**See instructions.

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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 $14,217**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **21,591** 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 fo
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 Departmen
during this cost report period. $ **228,413**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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% Ln14**
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
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