

Facility Name & ID Number Abbott House

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>106</u>	Intermediate (ICF)	<u>106</u>	<u>38,690</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,690</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>34,389</u>	<u>2,438</u>	<u>744</u>	<u>37,571</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>34,389</u>	<u>2,438</u>	<u>744</u>	<u>37,571</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.11%

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

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

YES NO

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

Date started 12/15/77

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	302,892	22,875	7,780	333,547		333,547		333,547		1
2	Food Purchase		241,200		241,200		241,200	(154)	241,046		2
3	Housekeeping	176,130	29,019		205,149		205,149		205,149		3
4	Laundry	57,797	6,967		64,764		64,764		64,764		4
5	Heat and Other Utilities			73,280	73,280		73,280		73,280		5
6	Maintenance	117,420	13,902	71,818	203,140		203,140	(3,718)	199,422		6
7	Other (specify):*										7
8	TOTAL General Services	654,239	313,963	152,878	1,121,080		1,121,080	(3,872)	1,117,208		8
	B. Health Care and Programs										
9	Medical Director			2,480	2,480		2,480		2,480		9
10	Nursing and Medical Records	843,924	28,309	19,742	891,975		891,975	(3,559)	888,416		10
10a	Therapy			7,000	7,000		7,000		7,000		10a
11	Activities	99,785	17,615	8,630	126,030		126,030		126,030		11
12	Social Services	190,728			190,728		190,728		190,728		12
13	CNA Training										13
14	Program Transportation			3,813	3,813		3,813		3,813		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,134,437	45,924	41,665	1,222,026		1,222,026	(3,559)	1,218,467		16
	C. General Administration										
17	Administrative	186,140		474,691	660,831		660,831	(299,691)	361,140		17
18	Directors Fees										18
19	Professional Services			93,085	93,085		93,085	(281)	92,804		19
20	Dues, Fees, Subscriptions & Promotions			58,467	58,467		58,467	(36,764)	21,703		20
21	Clerical & General Office Expenses	143,471	35,816	229,339	408,626		408,626	(172,084)	236,542		21
22	Employee Benefits & Payroll Taxes			450,774	450,774		450,774	(26,130)	424,644		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,496	10,496		10,496	(7,810)	2,686		24
25	Other Admin. Staff Transportation			454	454		454		454		25
26	Insurance-Prop.Liab.Malpractice			60,663	60,663		60,663	192	60,855		26
27	Other (specify):*							62,323	62,323		27
28	TOTAL General Administration	329,611	35,816	1,377,969	1,743,396		1,743,396	(480,246)	1,263,150		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,118,287	395,703	1,572,512	4,086,502		4,086,502	(487,677)	3,598,825		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			33,767	33,767	33,767	25,206	58,973				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,038	1,038	1,038	(242)	796				32
33	Real Estate Taxes			57,034	57,034	57,034		57,034				33
34	Rent-Facility & Grounds			244,044	244,044	244,044	(226,282)	17,762				34
35	Rent-Equipment & Vehicles			2,541	2,541	2,541	528	3,069				35
36	Other (specify):*											36
37	TOTAL Ownership			338,424	338,424	338,424	(200,790)	137,634				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			40,049	40,049	40,049	(40,049)	(0)				41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			40,049	40,049	40,049	(40,049)	(0)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,118,287	435,752	1,910,936	4,464,975	4,464,975	(728,516)	3,736,459				45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(129,145)	30		9
10	Interest and Other Investment Income	(242)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	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	(9,810)	20		20
21	Owner or Key-Man Insurance	(8,274)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(86,134)	21		24
25	Fund Raising, Advertising and Promotional	(21,041)	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	(173,451)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (428,252)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(300,264)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (300,264)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (728,516)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

BHF USE ONLY						
48		49		50		51
						52

Abbott House

	ID#	<u>0023739</u>
Report Period Beginning:		<u>01/01/14</u>
Ending:		<u>12/31/14</u>

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Expenses	\$ (40,049)	41	1
2	Non-Allowable Expense	(33,925)	21	2
3	Veterans Expenses	(3,559)	10	3
4	Open House Expense	(820)	21	4
5	Trust Fees	(120)	21	5
6	Annual Filing Fees - Bldg. Co	(250)	21	6
7	Accounting Fees - Bldg. Co.	(5,975)	19	7
8	State Replacement Tax - Bldg. Co	(2,593)	21	8
9	Non-Allowable Expense	(7,314)	21	9
10	Out of Period Legal Fees	(610)	19	10
11	Non-Care Depreciation	(19,323)	30	11
12	Out of State Seminars	(7,810)	24	12
13	Capitalized R&M	(6,861)	06	13
14	Additional R&M	3,143	06	14
15	Alliance for Living PAC Dues	(5,913)	20	15
16	Non-Allowable Expense	(41,472)	21	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	(173,451)		49

Abbott House

ID# 0023739

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Abbott House# 0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(154)											(154)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(3,718)											(3,718)	6
7	Other (specify):*													7
8	TOTAL General Services	(3,872)											(3,872)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,559)											(3,559)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(3,559)											(3,559)	16
	C. General Administration													
17	Administrative			(51,000)	(111,072)	(137,619)							(299,691)	17
18	Directors Fees													18
19	Professional Services	(6,585)	5,975		188	141							(281)	19
20	Fees, Subscriptions & Promotions	(36,764)											(36,764)	20
21	Clerical & General Office Expenses	(172,628)	2,843	(2,299)									(172,084)	21
22	Employee Benefits & Payroll Taxes	(8,274)		(17,856)									(26,130)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(7,810)											(7,810)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			192									192	26
27	Other (specify):*			22,734	22,289	17,300							62,323	27
28	TOTAL General Administration	(232,061)	8,818	(48,230)	(88,595)	(120,178)							(480,246)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(239,492)	8,818	(48,230)	(88,595)	(120,178)							(487,677)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14 Ending:

12/31/14

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	(148,468)	173,654	20									25,206	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(242)											(242)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(240,000)	13,718									(226,282)	34
35	Rent-Equipment & Vehicles			528									528	35
36	Other (specify):*													36
37	TOTAL Ownership	(148,710)	(66,346)	14,266									(200,790)	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	(40,049)											(40,049)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(40,049)											(40,049)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(428,252)	(57,528)	(33,964)	(88,595)	(120,178)							(728,516)	45

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 6-Supplemental		See 6-Supplemental		See 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 NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 240,000	Abbott House Realty, LLC	100.00%	\$	\$ (240,000)	1
2	V	33 R/E Tax Income	57,034	Abbott House Realty, LLC	100.00%		(57,034)	2
3	V	33 R/E Tax Reimb. Prior Year		Abbott House Realty, LLC	100.00%			3
4	V	33 R/E Taxes		Abbott House Realty, LLC	100.00%	57,034	57,034	4
5	V	21 Annual Filing Fee		Abbott House Realty, LLC	100.00%	250	250	5
6	V	19 Accounting Fee		Abbott House Realty, LLC	100.00%	5,975	5,975	6
7	V	30 Depreciation		Abbott House Realty, LLC	100.00%	173,654	173,654	7
8	V	21 State Replacement Tax		Abbott House Realty, LLC	100.00%	2,593	2,593	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 297,034			\$ 239,506	\$ * (57,528)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	997	\$	997	15
16	V	26 INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	192		192	16
17	V	30 DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	20		20	17
18	V	34 RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	13,718		13,718	18
19	V	35 EQUIPMENT RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	528		528	19
20	V								20
21	V	21 CLERICAL COMP		A.H.B. D/B/A ABH MANAGEMENT	100.00%	39,900		39,900	21
22	V	27 EMP. BEN.-DIRECT ALLOC.		A.H.B. D/B/A ABH MANAGEMENT	100.00%	22,734		22,734	22
23	V								23
24	V	17 HOME OFFICE	51,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%			(51,000)	24
25	V	21 HOME OFFICE CLERICAL	43,196	A.H.B. D/B/A ABH MANAGEMENT	100.00%			(43,196)	25
26	V	22 HOME OFFICE BENEFITS	17,856	A.H.B. D/B/A ABH MANAGEMENT	100.00%			(17,856)	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		\$ 112,053			\$ 78,089	\$ *	(33,964)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 100,000	\$ 100,000
16	V	19 PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	188	188
17	V	27 EMPLOYEE BENEFITS		KARLA BISHOP, INC.	100.00%	22,289	22,289
18	V						
19	V						
20	V						
21	V	17 MANAGEMENT FEES	211,072	KARLA BISHOP, INC.	100.00%		(211,072)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 211,072			\$ 122,477	\$ * (88,595)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 75,000	\$ 75,000
16	V	19 PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	141	141
17	V	27 EMPLOYEE BENEFITS		HEALTH RESOURCE, INC.	100.00%	17,300	17,300
18	V						
19	V	17 MANAGEMENT FEES	212,619	HEALTH RESOURCE, INC.	100.00%		(212,619)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 212,619			\$ 92,441	\$ * (120,178)

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	ALAN ROSENBAUM FAMILY TRUST	1.002%	BAYSIDE TERRACE LLC	WAUKEGAN	ABBOTT HOUSE REALTY, LLC		BUILDING CO.	1
2	CHARLES D. ZIS REVOCABLE TRUST	1.011%	HILLCREST RETIREMENT VILLAGE, LTD.	ROUND LAKE BEACH	KARLA BISHOP, INC.	LAKE BLUFF	MANAGEMENT CO.	2
3	CHRISTINE G. GARBER REV. TRUST	3.032%			A.H.B. D/B/A ABH MANAGEMEN	HIGHLAND PARK	HOME OFFICE	3
4	CHRISTINE GARBER	1.011%			HEALTH RESOURCE, INC.	HIGHLAND PARK	MANAGEMENT CO.	4
5	CORINNE AHRENS	0.500%						5
6	EARL L ROSENBAUM DECLARATION TRUST	40.533%						6
7	EDWARD AND NANCY OSMOLAK	4.896%						7
8	GEORGE M. ZAK	1.079%						8
9	H A KEATS & G A KEATS REALTY	1.079%						9
10	HEALTH RESOURCE INC.	1.000%						10
11	ILA ROSENBAUM	0.405%						11
12	IRA & MARJORIE MARGOLIS	2.021%						12
13	IRENE K. SILBERMAN REVOCABLE TRUST	3.238%						13
14	IVY FISHMAM FAMILY TRUST	1.002%						14
15	JACK R. FROST	0.505%						15
16	JAMES FROST	0.505%						16
17	JUDY ROSENBAUM	5.396%						17
18	KARLA BISHOP INC	14.124%						18
19	LAWRENCE JUTOVSKY TRUST	0.540%						19
20	LAWRENCE A SAVITT & BURT ROSENBERG	3.238%						20
21	MICHELLE SACKETT	1.079%						21
22	MITCHELL ROSENBAUM	0.405%						22
23	PAUL ROSENBAUM	0.405%						23
24	PHYLLIS J. BALMAT	1.079%						24
25	RALPH GOREN	1.079%						25
26	RALPH ROSENBAUM	0.405%						26
27	SANFORD AND BARBARA ALPER	1.000%						27
28	SANFORD AND NANCY RICHMAN	3.238%						28
29	SANDRA GOLD	1.619%						29
30	JUDITH JUTOVSKY TRUST 10/02/02	0.540%						30

Facility Name & ID Number

Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Moschel Family Irrevocable Trust	3.032						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 Abbott House # 0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ivy Fishman	Administrator	Administrative	0%	See Attached	40	100.00%	Salary	\$ 186,140	17-1	1
2	Karla Bishop	General Partner	Administrative	0%	See Attached	20	50.00%	Alloc.	100,000	17-7	2
3	Earl Rosenbaum	General Partner	Administrative	0%	See Attached	15	37.50%	Alloc.	75,000	17-7	3
4	Mitchell Rosenbaum	Maintenance	Maintenance	0.40%	See Attached	30	100.00%	Salary	44,122	6-1	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	\$ 405,262		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 Abbott House

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

0023739

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization A.H.B. D/B/A ABH MANAGEMENT
 Street Address 600 CENTRAL AVENUE
 City / State / Zip Code HIGHLAND PARK, IL 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	CLERICAL AND GENERAL	PATIENT DAYS	136,340	3	3,666	37,082	997	1	
2	26	INSURANCE	PATIENT DAYS	136,340	3	707	37,082	192	2	
3	30	DEPRECIATION	PATIENT DAYS	136,340	3	72	37,082	20	3	
4	34	RENT	PATIENT DAYS	136,340	3	50,436	37,082	13,718	4	
5	35	EQUIPMENT RENT	PATIENT DAYS	136,340	3	1,940	37,082	528	5	
6									6	
7	17	SALARY - A. ROSENBAUM	AVG. HOURS WORKED	40	1	20,000	20,000		7	
8	21	CLERICAL COMP	AVG. HOURS WORKED	40	1	39,900	39,900	40	39,900	8
9	27	EMP. BEN.-DIRECT ALLOC.	DIRECT		2	36,419		22,734	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					\$ 153,140	\$ 59,900	\$ 78,089	25	

Facility Name & ID Number Abbott House

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization KARLA BISHOP, INC.
 Street Address 271 RIVERS DRIVE
 City / State / Zip Code LAKE BLUFF, IL. 60044
 Phone Number (847)432-7262
 Fax Number (847)432-6095

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMIN. - KARLA BISHOP	AVG. HOURS WORKED	40	3	\$ 200,000	\$ 200,000	20	\$ 100,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	40	3	375	20	188	2	
3	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	40	3	44,578	20	22,289	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					\$ 244,953	\$ 200,000		\$ 122,477	25

Facility Name & ID Number Abbott House

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization HEALTH RESOURCE, INC.
 Street Address P.O. BOX 1275
 City / State / Zip Code HIGHLAND PARK, IL. 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED	40	3	\$ 200,000	\$ 200,000	15	\$ 75,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	40	3	375		15	141	2
3	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	40	3	46,133		15	17,300	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					\$ 246,508	\$ 200,000		\$ 92,441	25

Facility Name & ID Number Abbott House

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

0023739

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

0023739

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

0023739 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1								\$	\$			\$	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6		Auto		X					33,831			848	6						
7		JP Morgan Chase		X								190	7						
8													8						
9		TOTAL Facility Related						\$	\$ 33,831			\$ 1,038	9						
		B. Non-Facility Related*																	
10		Interest Income		X								(242)	10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$ (242)	14						
15		TOTALS (line 9+line14)						\$	\$ 33,831			\$ 796	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 Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	<u>55,000</u>		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.)		\$	<u>55,034</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	34		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>57,000</u>		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.		\$	<u>57,034</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>58,465</u>			8
	2010	<u>60,058</u>			9
	2011	<u>52,238</u>			10
	2012	<u>53,469</u>			11
	2013	<u>55,034</u>			12
2014 Accrual = \$55,034 x 1.035 = \$57,000 (rounded)					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2013	\$		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.

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

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

C. **Tax Bills**

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

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1977</u>	\$ <u>58,752</u>	1
2					2
3	TOTALS			\$ <u>58,752</u>	3

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	106	1977	1977	\$ 25,500	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1977	12,036		20			12,036
10	Various		1989	1,665		20			1,662
11	Various		1997	3,270		20	164	164	3,163
12	Various		1998	3,799		20	26	26	3,699
13	Various		2006	17,374		20			17,374
14	Various		2007	24,593		20	2,338	2,338	21,982
15	Various		2008	2,795		20			2,795
16	Various		2009	201,001		20	17,820	17,820	100,521
17	Various		2010	25,188		20	1,259	1,259	6,100
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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		1,434,435	173,654		21,168	(152,486)	539,283	67
68		2,454	20		55	35	2,028	68
69			14,444			(14,444)		69
70		\$ 1,754,109	\$ 188,118		\$ 42,830	\$ (145,288)	\$ 710,642	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,754,109	\$ 188,118		\$ 42,830	\$ (145,288)	\$ 710,642	1
2	Soffit And Siding	2011	5,910		20	591	591	1,872	2
3	Replace Smoke Detectors	2011	3,382		20	169	169	592	3
4	Roof Repair	2011	3,600		20			3,600	4
5	Repair Roof-Windows-Doors	2012	5,886		20	589	589	1,766	5
6	Install 1St Floor 2 Circuit For Front Office	2012	2,800		20	280	280	677	6
7	Sewer Repair	2012	3,641		20	364	364	759	7
8	Fire Alarm Repair Due To Water Damage	2012	7,558		20	756	756	1,575	8
9	Exterior Railings	2013	4,343		20	434	434	579	9
10	Fire Sprinklers For Porch Area	2013	5,400		20	540	540	630	10
11	New Concrete Service Walks	2013	2,560		20	256	256	363	11
12	Drywall Repairs	2013	3,564		20	178	178	342	12
13	Repaired Sanitary Sewer	2013	2,995		20	150	150	287	13
14	Electrical Work	2013	3,110		20	156	156	246	14
15	Electrical Work	2013	3,850		20	193	193	273	15
16	Exhaust Hood & Fire Prevention System	2014	23,200		20	1,547	1,547	1,547	16
17	2 Doors	2014	3,447		20	172	172	172	17
18	Backflow Preventer	2014	3,414		20	171	171	171	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)		\$ 1,842,770	\$ 188,118		\$ 49,375	\$ (138,743)	\$ 726,089	34

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

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,842,770	\$ 188,118		\$ 49,375	\$ (138,743)	\$ 726,089	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,842,770	\$ 188,118		\$ 49,375	\$ (138,743)	\$ 726,089	34

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

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,842,770	\$ 188,118		\$ 49,375	\$ (138,743)	\$ 726,089	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,842,770	\$ 188,118		\$ 49,375	\$ (138,743)	\$ 726,089	34

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

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,842,770	\$ 188,118		\$ 49,375	\$ (138,743)	\$ 726,089	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,842,770	\$ 188,118		\$ 49,375	\$ (138,743)	\$ 726,089	34

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

Facility Name & ID Number Abbott House

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3		1977	797,436	173,654	20		(173,654)		3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Various	1978	5,113		20			5,113	9
10	Various	1979	9,225		20			9,225	10
11	Various	1980	12,137		20			12,137	11
12	Various	1981	391		20			391	12
13	Various	1982	442		20			442	13
14	Various	1983	1,570		20			1,570	14
15	Various	1984	6,914		20			6,914	15
16	Various	1985	16,470		20			16,470	16
17	Various	1986	41,754		20			41,754	17
18	Various	1989	11,668		20			11,668	18
19	Various	1990	1,458		20			1,458	19
20	Various	1991	5,843		20			5,843	20
21	Various	1992	20,907		20			20,907	21
22	Various	1993	58,704		20			58,704	22
23	Various	1994	21,039		20			21,039	23
24	Various	1995	26,190		20	1,309	1,309	26,180	24
25	Various	1996	59,095		20	2,955	2,955	56,145	25
26	Various	1997	22,563		20	1,128	1,128	20,304	26
27	Various	1998	76,806		20	3,840	3,840	65,280	27
28	Various	1999	18,653		20	933	933	14,928	28
29	Various	2000	28,615		20	1,431	1,431	21,465	29
30	Various	2001	117,689		20	5,884	5,884	82,376	30
31	Various	2002	10,682		20	534	534	6,942	31
32	Various	2003	7,176		20	359	359	4,308	32
33	Various	2004	2,902		20	145	145	1,595	33
34	TOTAL (lines 1 thru 33)		\$ 1,381,442	\$ 173,654		\$ 18,518	\$ (155,136)	\$ 513,158	34

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

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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		\$ 1,381,442	\$ 173,654		\$ 18,518	\$ (155,136)	\$ 513,158	1
2	Various	2005	45,570		20	2,279	2,279	22,785	2
3	Fire Alarm System	2006	3,966		20	198	198	1,785	3
4	Replace Boiler Piping	2006	3,457		20	173	173	1,556	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,434,435	\$ 173,654		\$ 21,168	\$ (152,486)	\$ 539,283	34

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

Facility Name & ID Number Abbott House

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 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10	Allocated from ABH Management								10
11	Allocated from ABH Management	2002	2,316	20	20	55	35	1,890	11
12		2003	138					138	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)		\$ 2,454	\$ 20		\$ 55	\$ 35	\$ 2,028	34

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

Facility Name & ID Number Abbott House

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 2,454	\$ 20		\$ 55	\$ 35	\$ 2,028		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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,454	\$ 20		\$ 55	\$ 35	\$ 2,028		34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 97,388	\$	\$ 4,045	\$ 4,045	10	\$ 89,206	71
72	Current Year Purchases	6,657		555	555	10	555	72
73	Fully Depreciated Assets	427,996				10	427,996	73
74								74
75	TOTALS	\$ 532,041	\$	\$ 4,600	\$ 4,600		\$ 517,756	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		LEXUS LS460	2011	\$ 30,000	\$	\$ 4,998	\$ 4,998	5	\$ 22,503	76
77										77
78										78
79										79
80	TOTALS			\$ 30,000	\$	\$ 4,998	\$ 4,998		\$ 22,503	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,463,563	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 188,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,973	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (129,145)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,266,349	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	2012 BUICK ENCLAVE - 2012	\$ 53,342	\$ 11,322	\$ 45,342	86
87	Lexus LS460 - 2011	56,700	8,001	24,003	87
88					88
89					89
90					90
91	TOTALS	\$ 110,042	\$ 19,323	\$ 69,345	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 Abbott House

0023739

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				4,044			5
6	Alloc ABH Management				13,718			6
7	TOTAL				\$ 17,762			7

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 3,070 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	N/A	hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							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									13	
14	TOTAL			\$		\$	\$		\$	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.

Facility Name & ID Number Abbott House# 0023739Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 222,962	\$ 734,878	1
2	Cash-Patient Deposits	26,491	26,491	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	665,994	665,994	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,226	16,226	6
7	Other Prepaid Expenses	187	187	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	79,259	79,692	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,011,119	\$ 1,523,468	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		58,752	13
14	Buildings, at Historical Cost		1,391,921	14
15	Leasehold Improvements, at Historical Cost	316,919	316,919	15
16	Equipment, at Historical Cost	734,700	734,700	16
17	Accumulated Depreciation (book methods)	(748,338)	(2,027,320)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 303,281	\$ 474,972	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,314,400	\$ 1,998,440	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 157,837	\$ 157,836	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,292	25,292	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,949	100,949	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,292	8,292	31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,000	57,000	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	69,727	69,727	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 419,097	\$ 419,096	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	33,831	33,831	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	619,055		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 652,886	\$ 33,831	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,071,983	\$ 452,927	46
47	TOTAL EQUITY(page 18, line 24)	\$ 242,417	\$ 1,545,513	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,314,400	\$ 1,998,440	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 177,799	1
2	Restatements (describe):		2
3	Late Journal Entry	2,163	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 179,962	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	62,455	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 62,455	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)	\$ 242,417	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,434,907	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,434,907	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	35,096	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,096	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	242	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 242	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	57,185	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 57,185	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,527,430	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,121,080	31
32	Health Care	1,222,026	32
33	General Administration	1,743,396	33
B. Capital Expense			
34	Ownership	338,424	34
C. Ancillary Expense			
35	Special Cost Centers	40,049	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,464,975	40
41	Income before Income Taxes (line 30 minus line 40)**	62,455	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 62,455	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,934,721	44
45	Private Pay - Net Inpatient Revenue	395,736	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veterans</u>	104,450	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,434,907	49

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

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

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

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

Facility Name & ID Number Abbott House

0023739

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,080	\$ 87,821	\$ 42.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,624	8,182	248,973	30.43	3
4	Licensed Practical Nurses	7,714	8,171	198,211	24.26	4
5	CNAs & Orderlies	22,403	24,683	308,919	12.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,700	6,322	99,785	15.78	10
11	Social Service Workers	8,593	9,735	190,728	19.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,166	23,522	302,892	12.88	15
16	Dishwashers					16
17	Maintenance Workers	6,722	7,550	117,420	15.55	17
18	Housekeepers	10,083	11,324	176,130	15.55	18
19	Laundry	4,066	4,568	57,797	12.65	19
20	Administrator	2,080	2,080	186,140	89.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,945	9,923	143,471	14.46	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,048	118,140	\$ 2,118,287 *	\$ 17.93	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 7,780	01-03	35
36	Medical Director	Monthly	2,480	09-03	36
37	Medical Records Consultant	Monthly	12,902	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,840	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	7,000	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	8,630	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 45,632		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Ivy Fishman	Administrator	1.00%	\$ 186,140	Workers' Compensation Insurance	\$ 31,212	IDPH License Fee	\$		
				Unemployment Compensation Insurance	44,472	Advertising: Employee Recruitment	678		
				FICA Taxes	155,083	Health Care Worker Background Check			
				Employee Health Insurance	178,552	(Indicate # of checks performed <u>120.5</u>)	1,205		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	14,509		
				Other Employee Benefits	1,660	Licenses & Fees	5,311		
				Christmas Expense	13,664				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 186,140	TOTAL (agree to Schedule V, line 22, col.8)			\$ 424,644	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
Karla Bishop - Administrative			\$ 211,072				Yellow page advertising ()		
Health Resources, Inc - Management/Bookkeeping			212,619						
ABH Management - Management Fees			51,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 474,691						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 63,978			\$	Out-of-State Travel	\$	
See Attached	Legal		15,205						
Alexander Popa	Computer Consultant		9,188				In-State Travel		
Paychex	Payroll Processing		4,714						
							Seminar Expense	2,685	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 93,085	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 2,685	

* Attach copy of IMRF notifications

**See instructions.

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

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

