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: 0053561

Facility Name: Transitional Care of Arl Hts

Address: 1200 N Arl Hgts Rd (Number) | Arlington Hgts (City) | 60004 (Zip Code)

County: Cook

Telephone Number: (847) 392-9000 **Fax #** (847) 386-1028

HFS ID Number:

Date of Initial License for Current Owners:

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: Andrew Cutler **Telephone Number:** (847) 374 - 0400
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 1/16/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 374 - 0400 Fax # (847) 374 - 0420

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 Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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	1	689	14,219	14,909	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1	689	14,219	14,909	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 34.04%

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)
None

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 1/16/2016

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/16/2016 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 12,117

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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	339,357	18,687		358,044		358,044		358,044			1
2	Food Purchase		169,592		169,592		169,592	(15,170)	154,422			2
3	Housekeeping	119,348	21,710	14,847	155,905		155,905		155,905			3
4	Laundry		25,545		25,545		25,545		25,545			4
5	Heat and Other Utilities			113,424	113,424		113,424		113,424			5
6	Maintenance	81,342		93,350	174,692		174,692		174,692			6
7	Other (specify):*											7
8	**TOTAL General Services**	540,047	235,534	221,621	997,202		997,202	(15,170)	982,032			8
	B. Health Care and Programs											
9	Medical Director			39,721	39,721		39,721		39,721			9
10	Nursing and Medical Records	2,796,166	177,552	38,326	3,012,044		3,012,044		3,012,044			10
10a	Therapy	20,674			20,674		20,674		20,674			10a
11	Activities	64,550	3,584		68,134		68,134		68,134			11
12	Social Services	108,948		640	109,588		109,588		109,588			12
13	CNA Training											13
14	Program Transportation			15,687	15,687		15,687		15,687			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,990,338	181,136	94,374	3,265,848		3,265,848		3,265,848			16
	C. General Administration											
17	Administrative	141,590		432,650	574,240		574,240		574,240			17
18	Directors Fees											18
19	Professional Services			150,467	150,467		150,467		150,467			19
20	Dues, Fees, Subscriptions & Promotions			247,165	247,165		247,165	(78,330)	168,835			20
21	Clerical & General Office Expenses	449,448	211,217	146,969	807,634		807,634	(194,066)	613,568			21
22	Employee Benefits & Payroll Taxes			1,040,081	1,040,081		1,040,081		1,040,081			22
23	Inservice Training & Education											23
24	Travel and Seminar			24,290	24,290		24,290	(2,827)	21,463			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			190,428	190,428		190,428	102,849	293,277			26
27	Other (specify):*											27
28	**TOTAL General Administration**	591,038	211,217	2,232,050	3,034,305		3,034,305	(172,374)	2,861,931			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,121,423	627,887	2,548,045	7,297,355		7,297,355	(187,544)	7,109,811			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: Transitional Care of Arl Hts #0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			6,621	6,621		6,621	673,972	680,593			30
31	Amortization of Pre-Op. & Org.			7,382	7,382		7,382	9,767	17,149			31
32	Interest			19,549	19,549		19,549	720,297	739,846			32
33	Real Estate Taxes			(127,493)	(127,493)		(127,493)	390,608	263,115			33
34	Rent-Facility & Grounds			1,122,013	1,122,013		1,122,013	(1,122,013)				34
35	Rent-Equipment & Vehicles			32,124	32,124		32,124		32,124			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,060,196	1,060,196		1,060,196	672,631	1,732,827			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,521,551	726,563	167,396	2,415,510		2,415,510		2,415,510			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,881	82,881		82,881		82,881			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	1,521,551	726,563	250,277	2,498,391		2,498,391		2,498,391			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,642,974	1,354,450	3,858,518	10,855,942		10,855,942	485,087	11,341,029			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 Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(66,749)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(98,600)	21		24
25	Fund Raising, Advertising and Promotional	(58,188)	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	(133,667)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (357,204)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (357,204)		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

Transitional Care of Arl Hts

ID# 0053561

Report Period Beginning: 1/16/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank/ Credit Card Fees	$ (14,073)	21	1
2	Non-Allowable Penalty Interest	(62)	32	2
3	Marketing Director Wages	(81,393)	21	3
4	Marketing Consultant	(19,542)	20	4
5	Marketing Conusltant	(600)	20	5
6	Non-Allowable Seminar Expense	(2,224)	24	6
7	Dietary Offset	(15,170)	2	7
8	Non-Allowable Travel	(603)	24	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				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**	(133,667)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Transitional Care of Arl Hts **#** 0053561 **Report Period Beginning:** 1/16/2016 **Ending:** 12/31/2016

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,170)	0	0	0	0	0	0	0	0	0	0	(15,170)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,170)	0	0	0	0	0	0	0	0	0	0	(15,170)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(78,330)	0	0	0	0	0	0	0	0	0	0	(78,330)	20
21	Clerical & General Office Expenses	(194,066)	0	0	0	0	0	0	0	0	0	0	(194,066)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,827)	0	0	0	0	0	0	0	0	0	0	(2,827)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	102,849	0	0	0	0	0	0	0	0	0	102,849	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(275,223)	102,849	0	0	0	0	0	0	0	0	0	(172,374)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(290,393)	102,849	0	0	0	0	0	0	0	0	0	(187,544)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 **Report Period Beginning:** 1/16/2016 **Ending:** 12/31/2016

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	(66,749)	740,721	0	0	0	0	0	0	0	0	0	673,972	30
31	Amortization of Pre-Op. & Org.	0	9,767	0	0	0	0	0	0	0	0	0	9,767	31
32	Interest	(62)	720,359	0	0	0	0	0	0	0	0	0	720,297	32
33	Real Estate Taxes	0	390,608	0	0	0	0	0	0	0	0	0	390,608	33
34	Rent-Facility & Grounds	0	(1,122,013)	0	0	0	0	0	0	0	0	0	(1,122,013)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(66,811)	739,442	0	0	0	0	0	0	0	0	0	672,631	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(357,204)	842,291	0	0	0	0	0	0	0	0	0	485,087	45

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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
Lockwood AH Partners, LLC	20%	Winchester House	Libertyville	Arlington Heights Realty, LLC		BLDG Partnership
RSF Arlington Heights Holdings, LLC	80%					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,122,013	Arlington Heights Realty, LLC		$	$ (1,122,013)	1
2	V	30	Depreciation Expense		Arlington Heights Realty, LLC		740,721	740,721	2
3	V	31	Amortization Expense		Arlington Heights Realty, LLC		9,767	9,767	3
4	V	33	Real Estate Taxes		Arlington Heights Realty, LLC		390,608	390,608	4
5	V	26	Insurance		Arlington Heights Realty, LLC		102,849	102,849	5
6	V	32	Interest Expense		Arlington Heights Realty, LLC		720,359	720,359	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,122,013			$ 1,964,304	$ * 842,291	14

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

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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											11
12											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 Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 2/31/2016

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 Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Loan	X		Hud Mortgage			$	$ 19,656,590			$ 720,359	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital Funding		X	Term Loan	Various	07/2016	600,000				8,465	6
7	Capital Funding		X	Line of Credit				447,763			11,084	7
8	Due to Others/ST Notes		X	Working Capital				341,000				8
9	TOTAL Facility Related						$ 600,000	$ 20,445,353			$ 739,908	9
	B. Non-Facility Related*											
10	Interest Income		X								(62)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (62)	14
15	TOTALS (line 9+line14)						$ 600,000	$ 20,445,353			$ 739,846	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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 Transitional Care of Arl Hts # 0053561 **Report Period Beginning:** 1/16/2016 **Ending:** 12/31/2016

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.**	$		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.)	$	263,115	2
3. Under or (over) accrual (line 2 minus line 1).	$	263,115	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$		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.	$	263,115	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013		10
2014		11
2015	212,780	12

Building Partnership does not accrue for Real Estate Tax

	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 Transitional Care of Arl Hts COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053561

CONTACT PERSON REGARDING THIS REPORT Andrew Cutler, Managing Director

TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

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.	03-20-305-048-0000	1200 N ARLINGTON HEIGHTS RD	$ 18,757.13	$ 18,757.13
2.	03-20-305-048-0000	1200 N ARLINGTON HEIGHTS RD	$ 194,042.41	$ 194,042.41
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 212,799.54	$ 212,799.54

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 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 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 Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 71,217 B. General Construction Type: Exterior Brick/Hardie Frame Steel Number of Stories 2

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 88,585 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 7,382 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			2015	$ 2,119,137	1
2					2
3	TOTALS			$ 2,119,137	3

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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	120		2015	2015	$ 18,522,035	$	39	$ 474,924	$ 474,924	$ 474,924	4
5					732,364						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	Bldg Partnership Depreciation					740,721			(740,721)		35
36	Book Depreciation					6,621					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

Transitional Care of Arlington Heights
Reconcile to Capital Cost Report
0053561
1/1/2016-12/31/2016

6/30/2016 Capital Report

Page 12 XI Ownership B. BIMP	18,522,035.00
Page 13 XI Ownership C. EQIP	1,823,711.00

Final Cost Audit

Page 12 XI Ownership B. BIMP		Additions
Audited Construction Costs		
4/13/2016	Northern Glass, Inc.	1,728
4/13/2016	Northern Glass, Inc.	3,332
79/20/2016	ABCO Electrical Construction	17,920
Construction		**22,980**
Audited A&E		
8/31/2015	Construction Draw #21	6,201
12/31/2015	Construction Draw #25	5,406
A&E		**11,607**
Audited Consulting		
8/31/2015	Construction Draw #21	5,280
9/30/2015	Construction Draw #22	7,178
10/31/2015	Construction Draw #23	4,851
1/1/2016	Polsinelli PC	3,123
2/25/2016	Polsinelli PC	4,192
4/1/2016	RangeComm	100,000
1/1/2016	Kiefer Bonfanti	8,000
1/1/2016	Kiefer Bonfanti	8,000
4/18/2016	Kiefer Bonfanti	7,500
4/21/2016	RangeComm	94,560
4/27/2016	Marilyn P Dunn	13,103
8/10/2016	Lake Forest Bank	2,740
Consulting		**258,525**
Audited Other Costs		
	Capital Funding (on Closing)	321,880
	FHA Financing (on Clsoing)	98,960
	First American Title (HUD)	18,412
Other Costs		**439,252**
	Page 12 Building Cost Additions	**732,364**
	Previously Reported	**18,522,035**
Audited Page 12		**19,254,399**

Page 13 XI Ownership C EQIP		Additions
Audited Moveables		
8/31/2015	Construction Draw #21	41,088
9/30/2015	Construction Draw #22	57,050
10/31/2015	Construction Draw #23	22,013
12/31/2015	Construction Draw #25	28,106
Moveables		**148,257**
	Page 13 Equipment Cost Additions	**148,257**
	Previously Reported	**1,823,711**
Audited Page 13		**1,971,968**

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 19,254,399	$ 747,342		$ 474,924	$ (265,797)	$ 474,924	70

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

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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	$ 1,983,710	$	$ 199,545	$ 199,545	10	$ 200,010	71
72	Current Year Purchases	30,621		6,124	6,124	10	6,124	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,014,331	$	$ 205,669	$ 205,669		$ 206,134	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 23,387,867	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 747,342	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 680,593	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (66,749)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 681,058	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 Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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: $ 32,124 Description: Copier/ Fax Equipment Machines
(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.

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1	hrs	$ 650,839		$	$		$ 650,839	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	69,918					69,918	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	800,794					800,794	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				676,249		676,249	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): O2/Therapy Supplies	39-2					50,314		50,314	12
13	Other (specify): Lab/X-Ray/Equipment	39-3				167,396			167,396	13
14	TOTAL			$ 1,521,551		$ 167,396	$ 726,563		$ 2,415,510	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 Transitional Care of Arl Hts **#** 0053561 **Report Period Beginning:** 1/16/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(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	$ 58,474	$ 79,389	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 95,122)	1,063,037	1,063,037	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,809	154,809	6
7	Other Prepaid Expenses	15,439	66,237	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		1,855,990	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,291,759	$ 3,219,462	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,119,137	13
14	Buildings, at Historical Cost	1,194	18,713,028	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	41,169	2,009,232	16
17	Accumulated Depreciation (book methods)	(6,621)	(747,342)	17
18	Deferred Charges	733	733	18
19	Organization & Pre-Operating Costs	88,585	674,588	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,382)	(17,149)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		3,837,026	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 117,678	$ 26,589,253	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,409,437	$ 29,808,715	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 778,203	$ 778,203	26
27	Officer's Accounts Payable		150,000	27
28	Accounts Payable-Patient Deposits	(161)	(161)	28
29	Short-Term Notes Payable		241,000	29
30	Accrued Salaries Payable	265,783	265,783	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		234,080	32
33	Accrued Interest Payable		56,513	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,043,825	$ 1,725,418	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	547,763	547,763	39
40	Mortgage Payable		19,656,590	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	3,837,026	3,837,026	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,384,789	$ 24,041,379	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,428,614	$ 25,766,797	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,019,177)	$ 4,041,918	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,409,437	$ 29,808,715	48

***(See instructions.)**

	A. Current Assets	Operating	After Consolidation
9	Debt Service Reserve Escrow		1,102,012.00
	Replacement Reserve Escrow		134,376.00
	Taxes & Insurance Escrow		619,512.00
	Misc. Receivables		90.00
		-	1,855,990.00

	B. Long-Term Assets	Amount	
23	Due From Tenant	-	3,837,026.00
		-	3,837,026.00

	Other Long Term Liabilities	Amount	
43	Due To Landlord	3,837,026.00	3,837,026.00
		3,837,026.00	3,837,026.00

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,233,309)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,233,309)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,785,868)	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)**	$ (2,785,868)	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)**	$ (4,019,177)	24 *

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

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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	$ 6,713,028	1
2	Discounts and Allowances for all Levels	(5,819,066)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 893,962	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,595,075	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,595,075	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	1,788	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,354,063	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	71,609	19
20	Radiology and X-Ray	42,990	20
21	Other Medical Services	90,755	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,561,205	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Film Location Revenue	1,000	28
28a	Employee/Guest Meals/Overnight Guest	18,770	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,770	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,070,074	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	997,202	31
32	Health Care	3,265,848	32
33	General Administration	3,034,305	33
	B. Capital Expense		
34	Ownership	1,060,196	34
	C. Ancillary Expense		
35	Special Cost Centers	2,415,510	35
36	Provider Participation Fee	82,881	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,855,942	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,785,868)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,785,868)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 164	44
45	Private Pay - Net Inpatient Revenue	212,354	45
46	Medicare - Net Inpatient Revenue	664,349	46
47	Other-(specify) Managed Care	17,626	47
48	Other-(specify) Hospice	(531)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 893,962	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 Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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	2,092	2,237	$ 107,548	$ 48.08	1
2	Assistant Director of Nursing	2,011	2,083	84,856	40.75	2
3	Registered Nurses	46,203	47,745	1,647,602	34.51	3
4	Licensed Practical Nurses	10,608	10,852	303,574	27.97	4
5	CNAs & Orderlies	41,344	42,609	636,722	14.94	5
6	CNA Trainees					6
7	Licensed Therapist	35,538	36,929	1,521,551	41.20	7
8	Rehab/Therapy Aides	1,417	1,441	20,674	14.34	8
9	Activity Director	1,487	1,635	42,734	26.14	9
10	Activity Assistants	1,510	1,544	21,816	14.13	10
11	Social Service Workers	3,879	4,065	108,948	26.80	11
12	Dietician	2,016	2,056	68,253	33.20	12
13	Food Service Supervisor	4,314	4,442	113,295	25.50	13
14	Head Cook	12,857	13,240	157,809	11.92	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,951	2,996	81,342	27.15	17
18	Housekeepers	8,642	8,973	119,348	13.30	18
19	Laundry					19
20	Administrator	2,288	2,044	141,590	69.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,924	17,660	449,447	25.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,031	1,089	15,865	14.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	197,113	203,641	$ 5,642,974 *	$ 27.71	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		$		35
36	Medical Director	Monthly	39,721	9-3	36
37	Medical Records Consultant	Monthly	31,138	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,074	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	25	640	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	25	$ 76,573		49

C. CONTRACT NURSES

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

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Megan Mulherin	Administrator	0	$ 47,468
Lisa Ulm	Administrator	0	81,197
Sarah Glumm	Administrator	0	9,032
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 137,697

B. Administrative - Other

Description	Amount
Management Fee	$ 432,650
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 432,650

C. Professional Services

Vendor/Payee	Type	Amount
Much Shelist	Legal	$ 13,195
FGMK, LLC	Accounting	33,750
ADP/Paycheck	Payroll Processing	46,361
Nancy Arnold	Business Development	2,605
Benjamin Filippo	Spreadsheet Consulting	300
Transitional Care Management	AP/HR Consulting	27,780
Stone, McGuire & Siegel, PC	Healthcare Consulting	11,761
Pinnacle Quality Insight	Customer Satisfaction Surveys	2,640
Strategic Dining Services	Dining Services	12,000
Marcum, LLP	Healthcare Consulting	75
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 150,467

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 160,488
Unemployment Compensation Insurance	
FICA Taxes	407,519
Employee Health Insurance	310,319
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Payroll Taxes - SUCI	83,452
Payroll Taxes - FUTA	8,601
EE Disability/Life/Dental/Vision Insur	9,632
401k Expense	1,350
Other Employee Benefits	58,720
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,040,081

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	137,749
Health Care Worker Background Check	4,974
(Indicate # of checks performed)	
Patient Background Checks	6,956
Dues & Subscriptions	6,797
Marketing Costs	58,188
Licenses	12,359
Less: Public Relations Expense	( )
Non-allowable advertising	(58,188)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 168,835

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,102
Seminar Expense	13,361
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,463

* Attach copy of IMRF notifications

**See instructions.

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	ADJ
1/31/2016	PEL/VIP	In-Service, Mucus Clearance			Arlington Heights , IL	125	
2/1/2016	Allison Consulting	CEU Seminars - Winter/Spring Courses			Arlington Heights, IL	5,006	
2/10/2016	TCAH Payroll	HIPAA CEU	J Buchler	Dir of Rehab	Webinar - AH, IL	249	
2/29/2016	PICC ME Vascular Solutions	Education Hours			Arlington Heights, IL	350	
2/1/2016	PEL/VIP	In-Service, Nebulizer			Arlington Heights, IL	125	
2/29/2016	Continuing Education Institute of IL	Living with Lymphedema			AH & Des Plaines, IL	675	
3/23/2016	TCAH Payroll	NARA Conference	J Buchler	Dir of Rehab	Washington, DC	541	ADJ
3/31/2016	CHELA	Admission and Oversight Training	Admission Staff	Admission	Arlington Heights, IL	2,500	
4/6/2016	TCAH Payroll	Wipeout Wounds 2016	C Dolak	RN	Glenview, IL	60	
4/30/2016	TCAH Payroll	Stroke Rehab CEU	E Brucks	Speech Therapist	Chicago, IL	298	
5/25/2016	Olivia Christiansen	IHCA Conference	Lisa Ulm	Administrator	Peoria, IL	95	
7/14/2016	Denise Norman	PCC Summit	J Buchler	Dir of Rehab	Orlando, FL	1,497	ADJ
7/20/2016	Sarah Glumm	Proactive Webinar	S Glumm	Chief Clinical Officer	Webinar - AH, IL	149	
3/10/2016	Continuing Education Institute of IL	AH Training			Arlington Heights, IL	315	
4/4/2016	Continuing Education Institute of IL	LGBTQ Program			Arlington Heights, IL	25	
6/2/2016	Continuing Education Institute of IL	Pain			Arlington Heights, IL	195	
5/10/2016	Continuing Education Institute of IL	LGBTQ Program, Therapy, Animal Assisted Healthcare			Arlington Heights, IL	555	
7/13/2016	Continuing Education Institute of IL	AH Successful Rehab, New Wave of Accountability			AH & Elk Grove	90	
9/7/2016	TCAH Payroll	Medicare Training	H Patel	Biller	Webinar - AH, IL	55	
9/30/2016	PICC ME Vascular Solutions	CEU - Centrail Line Class			Arlington Heights, IL	350	
10/6/2016		Cancelled Airfare due to JCAH Meeting	S Glumm	Chief Clinical Officer	Fort Myers, FL	186	ADJ
3/10/2016	Continuing Education Institute of IL	Reversal			Arlington Heights, IL	(360)	
7/20/2016	Continuing Education Institute of IL	New Wave of Accountability			Arlington Heights, IL	225	
10/7/2016	Continuing Education Institute of IL	LGBTQ Competency in Healthcare			Barrington & AH, IL	465	
10/31/2016	CE Solutions	Monthly Prepaid Expense Write-Off			Webinar - AH, IL	359	
11/4/2016	Kurtz Ambulance Service Inc	AHA CPR Training Books			Arlington Heights, IL	270	
11/30/2016	CE Solutions	Monthly Prepaid Expense Write-Off			Webinar - AH, IL	359	
12/14/2016	TCAH Payroll	CPT Webinar	J Buchler	Dir of Rehab	Webinar - AH, IL	99	
12/28/2016	TCAH Payroll	Adult Weight Management	K Baldazo	Dietitian	Webinar - AH, IL	370	
12/31/2016	CE Solutions	Monthly Prepaid Expense Write-Off			Webinar - AH, IL	359	
				Adjustment		(2,224)	
						13,361	

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILEAGE	AIRFARE	PARKING	TOTAL	ADJ
12/14/2016	Julia Buchler	Therapy Director	Optima Conference	Conference		280		280	
2016	Terri Galloway	Recruiter	TCAH	Meetings	1,009			1,009	
2016	Olivia Christiansen	HR/AP	TCAH	Meetings/work	811			811	
2016	Alvin Pangilinan	HR/AP	TCAH	work at building	659			659	
12/19/2016	Charles Ross	Business Development	BCBS Chicago	Meeting			21	21	
2016	Vicky Steciuk	Case Manager	various hospital visits	case mgmt	1,583			1,583	
2016	Lisa Henderson	Marketing director	various	marketing	603			603	ADJ
2016	Myra Valera	Nurse Liaison	various hospital visits	case mgmt	2,469			2,469	
2016	C.Sodora	Admissions	various local	admissions	34			34	
2016	S. Foster	HR	local		41			41	
2016	M. Lauer	Nurse Liaison		Meetings	881			881	
2016	J. Buchler	Therapy Director			313			313	
								-	
				Adjustment	(603)			(603)	
								-	
								-	
					7,801			8,102	

Transitional Care of Arlington Heights
0053561
Page 21 Supp - Legal
1/16/2016-12/31/2016

DATE	G/L ACCT.	PAYEE/VENDOR	AMOUNT
2/1/2016	80550	Much Shelist	563
4/1/2016	80550	Much Shelist	2,413
4/1/2016	80550	Much Shelist	749
6/1/2016	80550	Much Shelist	150
4/1/2016	80550	Much Shelist	225
4/1/2016	80550	Much Shelist	749
4/1/2016	80550	Much Shelist	803
10/18/2016	80550	Much Shelist	4,969
11/1/2016	80550	Much Shelist	2,500
7/31/2016	80550	Much Shelist	75
		TOTAL:	13,195

Facility Name & ID Number Transitional Care of Arl Hts # 0053561 Report Period Beginning: 1/16/2016 Ending: 12/31/2016

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **204** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions 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. $ **82,881**
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. $ **No** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **0**

(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? **Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **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. **No**
Attach invoices and a summary of services for all architect and appraisal fees