FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 Arlington Heights

Address: 1200 N. Arlington Heights Rd (Number) | Arlington Heights (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: 9/17/15

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 B. 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 1/1/2017 to 12/31/2017 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 B. Cutler, Managing Director, Healthcare
(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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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		1,204	28,125	29,329	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		1,204	28,125	29,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.96%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 20,157

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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	589,906	48,459		638,365		638,365		638,365			1
2	Food Purchase		301,199		301,199		301,199	(20,487)	280,712			2
3	Housekeeping	197,690	48,946	41,893	288,529		288,529		288,529			3
4	Laundry		27,365		27,365		27,365		27,365			4
5	Heat and Other Utilities			137,108	137,108		137,108		137,108			5
6	Maintenance	70,717		101,338	172,055		172,055	(6,052)	166,003			6
7	Other (specify):*											7
8	TOTAL General Services	858,313	425,969	280,339	1,564,621		1,564,621	(26,539)	1,538,082			8
	B. Health Care and Programs											
9	Medical Director			50,625	50,625		50,625		50,625			9
10	Nursing and Medical Records	4,139,654	231,689	122,990	4,494,333		4,494,333		4,494,333			10
10a	Therapy	36,394			36,394		36,394		36,394			10a
11	Activities	128,095	5,401		133,496		133,496		133,496			11
12	Social Services	237,114		5,907	243,021		243,021		243,021			12
13	CNA Training											13
14	Program Transportation			10,368	10,368		10,368		10,368			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,541,257	237,090	189,890	4,968,237		4,968,237		4,968,237			16
	C. General Administration											
17	Administrative	142,306		819,071	961,377		961,377		961,377			17
18	Directors Fees											18
19	Professional Services			150,159	150,159		150,159	(236)	149,923			19
20	Dues, Fees, Subscriptions & Promotions			291,060	291,060		291,060	(127,609)	163,451			20
21	Clerical & General Office Expenses	565,023	241,007	236,581	1,042,611		1,042,611	(263,341)	779,270			21
22	Employee Benefits & Payroll Taxes			1,867,850	1,867,850		1,867,850		1,867,850			22
23	Inservice Training & Education											23
24	Travel and Seminar			36,088	36,088		36,088	(3,168)	32,920			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			213,051	213,051		213,051	152,047	365,098			26
27	Other (specify):*											27
28	TOTAL General Administration	707,329	241,007	3,613,860	4,562,196		4,562,196	(242,307)	4,319,889			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,106,899	904,066	4,084,089	11,095,054		11,095,054	(268,846)	10,826,208			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 Arlington Heights #0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,465	13,465		13,465	683,362	696,827			30
31	Amortization of Pre-Op. & Org.			29,528	29,528		29,528	14,650	44,178			31
32	Interest			75,382	75,382		75,382	672,268	747,650			32
33	Real Estate Taxes							362,871	362,871			33
34	Rent-Facility & Grounds			1,493,742	1,493,742		1,493,742	(1,493,742)				34
35	Rent-Equipment & Vehicles			41,778	41,778		41,778		41,778			35
36	Other (specify):*											36
37	TOTAL Ownership			1,653,895	1,653,895		1,653,895	239,409	1,893,304			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,505,554	1,382,205	425,393	4,313,152		4,313,152		4,313,152			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,233	121,233		121,233		121,233			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	2,505,554	1,382,205	546,626	4,434,385		4,434,385		4,434,385			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,612,453	2,286,271	6,284,610	17,183,334		17,183,334	(29,437)	17,153,897			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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	(279,713)	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	(163,821)	21		24
25	Fund Raising, Advertising and Promotional	(71,073)	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	(187,449)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (702,056)		$	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))**	$ (702,056)		37

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

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

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

STATE OF ILLINOIS

Transitional Care of Arlington Heights

ID# 0053561

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank/ Credit Card Fees	$ (26,128)	21	1
2	Non-Allowable Interest	(1,450)	32	2
3	Marketing Director Wages	(73,075)	21	3
4	Marketing Consultant	(56,536)	20	4
5	Dietary Offset	(20,487)	2	5
6	Non-Allowable Travel	(1,084)	24	6
7	Misc. Income	(20)	21	7
8	Non-Allowable Travel & Entertainment	(297)	21	8
9	Capitalized R&M	(6,052)	6	9
10	Non-Allowable Mileage	(2,084)	24	10
11	Non-Allowable Legal	(236)	19	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**	(187,449)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(20,487)	0	0	0	0	0	0	0	0	0	0	(20,487)	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	(6,052)	0	0	0	0	0	0	0	0	0	0	(6,052)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(26,539)	0	0	0	0	0	0	0	0	0	0	(26,539)	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	(236)	0	0	0	0	0	0	0	0	0	0	(236)	19
20	Fees, Subscriptions & Promotions	(127,609)	0	0	0	0	0	0	0	0	0	0	(127,609)	20
21	Clerical & General Office Expenses	(263,341)	0	0	0	0	0	0	0	0	0	0	(263,341)	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	(3,168)	0	0	0	0	0	0	0	0	0	0	(3,168)	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	152,047	0	0	0	0	0	0	0	0	0	152,047	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(394,354)	152,047	0	0	0	0	0	0	0	0	0	(242,307)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(420,893)	152,047	0	0	0	0	0	0	0	0	0	(268,846)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Transitional Care of Arlington Heights** **#** **0053561** **Report Period Beginning:** **1/1/2017** **Ending:** **12/31/2017**

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	(279,713)	963,075	0	0	0	0	0	0	0	0	0	683,362	30
31	Amortization of Pre-Op. & Org.	0	14,650	0	0	0	0	0	0	0	0	0	14,650	31
32	Interest	(1,450)	673,718	0	0	0	0	0	0	0	0	0	672,268	32
33	Real Estate Taxes	0	362,871	0	0	0	0	0	0	0	0	0	362,871	33
34	Rent-Facility & Grounds	0	(1,493,742)	0	0	0	0	0	0	0	0	0	(1,493,742)	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**	(281,163)	520,572	0	0	0	0	0	0	0	0	0	239,409	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)**	(702,056)	672,619	0	0	0	0	0	0	0	0	0	(29,437)	45

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 1,493,742	Arlington Heights Realty, LLC		$	$ (1,493,742)	1
2	V	30	Depreciation Expense		Arlington Heights Realty, LLC		963,075	963,075	2
3	V	31	Amortization Expense		Arlington Heights Realty, LLC		14,650	14,650	3
4	V	33	Real Estate Taxes		Arlington Heights Realty, LLC		362,871	362,871	4
5	V	26	Insurance		Arlington Heights Realty, LLC		152,047	152,047	5
6	V	32	Interest Expense		Arlington Heights Realty, LLC		673,718	673,718	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,493,742			$ 2,166,361	$ * 672,619	14

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

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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28								28
29								29
30								30

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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			$	$ 19,418,033			$ 673,718	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Due to Landlord	X		Working Capital				4,377,026				6
7	Capital Funding		X	LOC				538,480			75,382	7
8	Due to Others/ST Notes	X		Working Capital				100,000				8
9	TOTAL Facility Related						$	$ 24,433,539			$ 749,100	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,450)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,450)	14
15	TOTALS (line 9+line14)						$	$ 24,433,539			$ 747,650	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 Arlington Heights # 0053561 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	$	362,871	2
3. Under or (over) accrual (line 2 minus line 1).	$	362,871	3
4. Real Estate Tax accrual used for 2017 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.	$	362,871	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014		10
2015	212,780	11
2016	296,951	12

Building Partnership does not accrue for Real Estate Tax

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Transitional Care of Arlington Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053561

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-20-305-048-000	1200 N. Arlington Heights Rd.	$ 296,950.67	$ 296,950.67
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 296,950.67	$ 296,950.67

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 29,528 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		182,852	2015	$ 2,119,137	1
2					2
3	TOTALS	182,852		$ 2,119,137	3

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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		2016	2016	$ 18,522,035	$	39	$ 474,924	$ 474,924	$ 949,848	4
5			2016	2016	732,364		39	18,779	18,779	18,779	5
6											6
7											7
8											8
	Improvement Type**										
9	Facility Generator Repair			2017	6,052		20	151	151	151	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	Building Partnership Depreciation					963,075			(963,075)		35
36	Book Depreciation					13,465					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 Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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)		$ 19,260,451	$ 976,540		$ 493,854	$ (469,221)	$ 968,778	70

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

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 2,014,331	$	$ 201,433	$ 201,433	10	$ 407,567	71
72	Current Year Purchases	30,804		1,540	1,540	10	1,540	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,045,135	$	$ 202,973	$ 202,973		$ 409,107	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)	$ 23,424,723	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 976,540	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 696,827	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (279,713)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,377,885	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.

Transitional Care of Arlington Heights
0053561
Equipment Breakout
1/1/2017-12/31/2017

AH Realty, LLC	Cost Basis	Life	S/L Depreciation
Purchased in PY	1,973,162	10	197,316
CY Purchases	-		
Fully Depreciated Assets	-		
Total	1,973,162		197,316
Transitional Care of Arlington Heights			
Purchased in PY	41,169	10	4,117
CY Purchases	30,804	10	1,540
Fully Depreciated Assets	-		
Total	71,973		5,657
Totals			
Purchased in PY	2,014,331	10	201,433
CY Purchases	30,804	10	1,540
Fully Depreciated Assets	-		
Total	2,045,135		202,973

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 ☒ 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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 41,778 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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-1	hrs	$ 1,037,850		$	$		$ 1,037,850	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	138,908					138,908	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	1,328,796					1,328,796	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				1,302,329		1,302,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): O2 Therapy Supplies	39-2					79,876		79,876	12
13	Other (specify): Lab/Xray/Equipment	39-3				425,393			425,393	13
14	TOTAL			$ 2,505,554		$ 425,393	$ 1,382,205		$ 4,313,152	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 Arlington Heights **#** 0053561 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ (200,281)	$ 15,650	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (212,207))	1,605,779	1,605,779	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,165	161,165	6
7	Other Prepaid Expenses	23,863	73,457	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		1,687,667	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,590,526	$ 3,543,718	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	18,752,328	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	71,973	2,040,036	16
17	Accumulated Depreciation (book methods)	(20,085)	(1,683,712)	17
18	Deferred Charges	38,800	38,800	18
19	Organization & Pre-Operating Costs	88,585	674,588	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(36,910)	(61,327)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		4,477,026	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 143,557	$ 26,356,876	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,734,083	$ 29,900,594	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,042,774	$ 1,042,774	26
27	Officer's Accounts Payable		162,530	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	345,823	345,823	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		300,000	32
33	Accrued Interest Payable		55,827	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	148,371	148,371	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,536,968	$ 2,055,325	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,418,033	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	5,015,506	5,015,506	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,015,506	$ 24,433,539	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,552,474	$ 26,488,864	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,818,391)	$ 3,411,730	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,734,083	$ 29,900,594	48

***(See instructions.)**

Transitional Care of Arlington Heights
0053561
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1/1/17-12/31/2017

	Current Assets	Operating	After Consolidation
9	Debt Service Reserve Escrow		1,105,322
	Replacement Reserve Escrow		325,427
	Taxes & Insurance Escrow		256,918
		-	1,687,667

	Long-Term Assets	Amount	
23	Due From Tenant	-	4,377,026
	Due From Tenant		100,000
		-	4,477,026

	Current Liabilities	Amount	
36	Due BCBS	148,371	148,371
		148,371	148,371

	Other Long Term Liabilities	Amount	
43	Due To Landlord	4,377,026	4,377,026
	LOC Cap Funding	538,480	538,480
	Due to Other	100,000	100,000
		5,015,506	5,015,506

Facility Name & ID Number Transitional Care of Arlington Heights **#** 0053561 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,019,177)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,019,177)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(799,214)	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)**	$ (799,214)	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)**	$ (4,818,391)	24 *

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

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 13,230,555	1
2	Discounts and Allowances for all Levels	(10,891,282)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,339,273	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,855,630	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,855,630	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	300	13
14	Non-Patient Meals	20,487	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,120	16
17	Sale of Drugs	2,692,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	176,131	19
20	Radiology and X-Ray	112,723	20
21	Other Medical Services	181,376	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,187,747	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,450	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,450	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	20	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,384,120	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,564,621	31
32	Health Care	4,968,237	32
33	General Administration	4,562,196	33
	B. Capital Expense		
34	Ownership	1,653,895	34
	C. Ancillary Expense		
35	Special Cost Centers	4,313,152	35
36	Provider Participation Fee	121,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,183,334	40
41	**Income before Income Taxes (line 30 minus line 40)****	(799,214)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (799,214)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue	396,103	45
46	Medicare - Net Inpatient Revenue	1,656,605	46
47	Other-(specify) Managed Care	286,565	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,339,273	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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	1,512	1,648	$ 80,848	$ 49.06	1
2	Assistant Director of Nursing	4,446	4,605	180,319	39.16	2
3	Registered Nurses	59,447	62,419	2,434,613	39.00	3
4	Licensed Practical Nurses	14,383	15,265	500,075	32.76	4
5	CNAs & Orderlies	58,798	62,131	879,324	14.15	5
6	CNA Trainees					6
7	Licensed Therapist	60,677	63,290	2,505,554	39.59	7
8	Rehab/Therapy Aides	1,806	1,863	36,394	19.54	8
9	Activity Director	3,151	3,295	53,378	16.20	9
10	Activity Assistants	4,654	4,773	74,717	15.65	10
11	Social Service Workers	4,435	4,650	237,114	50.99	11
12	Dietician	3,138	3,276	110,268	33.66	12
13	Food Service Supervisor	3,892	4,291	74,294	17.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,783	31,185	405,344	13.00	15
16	Dishwashers					16
17	Maintenance Workers	1,928	2,080	70,717	34.00	17
18	Housekeepers	14,054	14,793	197,690	13.36	18
19	Laundry					19
20	Administrator	2,037	2,272	115,318	50.76	20
21	Assistant Administrator	1,120	1,120	26,988	24.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,464	23,863	600,405	25.16	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	1,869	2,087	29,093	13.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	293,594	308,906	$ 8,612,453 *	$ 27.88	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	50,625	9-3	36
37	Medical Records Consultant	Monthly	24,735	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,666	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	82	5,907	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	82	$ 94,933		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	196	$ 13,873	10-3	50
51	Licensed Practical Nurses	77	4,207	10-3	51
52	Certified Nurse Assistants/Aides	3,646	66,508	10-3	52
53	TOTAL (lines 50 - 52)	3,919	$ 84,588		53

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Mabe	Administrator	0	$ 115,318
Ashley Davis	Asst. Administrator	0	26,029
Myra Valera	Weekend Admin.	0	959
Note Prior Administrators - Lisa Ulm (Termed 1/6/17) -Jason Lee (1/9/17-11/9/17)			
Prior Assistant Administrator (Brigette Penalber (1/1/17-9/18/17)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 142,306

B. Administrative - Other

Description	Amount
Management Fee	$ 819,071
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 819,071

C. Professional Services

Vendor/Payee	Type	Amount
ADP/Paychecks	Payroll Processing	$ 74,474
Much Shellist	Legal	9,471
SMART	Accounting	800
Pinnacle Quality Insight	Customer Svc	2,880
Ben Filippo	Spreadsheet Consulting	197
CECS	CECS Prep	450
Stone McGuire	Healthcare Consulting	12,705
FGMK	Accounting /Consulting	30,168
Marcum	Healthcare Consulting	7,359
Meghan Mulherin	Consulting	6,157
Stone McGuire	Legal	5,498
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 150,159

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 245,648
Unemployment Compensation Insurance	
FICA Taxes	744,874
Employee Health Insurance	808,811
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	14,725
Other Employee Benefits	53,792
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,867,850

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	136,672
Health Care Worker Background Check	1,485
(Indicate # of checks performed)	
Patient Background Checks	13,502
Dues & Subscriptions	9,258
Licenses	2,534
Marketing Expense	127,609
Less: Public Relations Expense	( )
Non-allowable advertising	(127,609)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 163,451

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	17,658
Seminar Expense	15,262
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,920

* Attach copy of IMRF notifications

**See instructions.

Transitional Care of Arlington Heights
0053561
Seminar Schedule
1/1/17-12/31/2017

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
01/31/17	CE Solutions	Various	Various	Various	Online	358.59
02/09/17	F-Tag Manual	F-Tag Manual	S. Glumm	Chief Clinical Officer	Webinar	98.43
02/15/17	Nara	Nara Spring Conf.	J. Buchler	Dir. Of Rehab	In-State	425.00
02/16/17	HCPro	50 PCS HIPAA Handbook	LTC Staff	Clinical		410.76
02/28/17	CE Solutions	Various	Various	Various	Online	358.59
03/08/17	Denise Norman	Ortho Cert Course	A. Miller/M. Patpilo	Therapy		1,079.07
02/28/17	IHCA	January Training	TCM	Various	Online	27.50
02/28/17	IHCA	February Training	TCM	Various	Online	55.00
03/31/17	Picc Me Vascular Solutions	Central Line Class	LTC Staff	Clinical	Online	350.00
03/31/17	IHCA	March Training	TCM	Various	Online	27.50
03/31/17	CE Solutions	Various	Various	Various	Online	358.59
03/16/17	Kurtz Ambulance Service	AHA BLS Class	Various	Clinical	Online	119.00
04/30/17	Picc Me Vascular Solutions	Central Line Class	LTC Staff	Clinical	Online	525.00
04/30/17	K. Leicht	reasoning w/ unreasonable people	K. Leicht			79.00
04/30/17		Emergency Preparedness	Glumm	Chief Clinical Officer		164.22
04/30/17	CE Solutions	Various	Various	Various	Online	358.59
05/17/17	A. Miller	CPR	A. Miller	Therapy		65.00
05/31/17	HCPro	Medpass Policies	Various	Clinical		195.00
05/31/17	CE Solutions	Various	Various	Various	Online	358.59
05/31/17	IHCA	May Training	TCM	Various	Online	27.90
06/30/17	Picc Me Vascular Solutions	Central Line Class	LTC Staff	Clinical	Online	350.00
06/30/17	IHCA	Food Saftey Seminar	TCM	Various	Online	146.30
06/30/17	CE Solutions	Various	Various	Various	Online	358.59
07/31/17	IHCA	July Training	TCM	Various	Online	(35.00)
07/31/17	CE Solutions	Various	Various	Various	Online	358.59
08/31/17	CE Solutions	Various	Various	Various	Online	358.59
09/14/17	Nancy Hartman	Wound Care Module Training	LTC Staff	Clinical	Online	448.00
09/20/17	K. Baldazo	Food and Nutrition Conf.	K. Baldazo	Dietician		395.00
09/20/17	M. Lauer	Aseptic Training				24.95
09/29/17	IHCA	Fall and restraint	LTC Staff	Clinical	Webinar	150.00
09/30/17	L. Reinecke	Intellicentrics Training	L. Reinecke			59.54
09/30/17	T. Moreno	Excel Training	T. Moreno	Administrative	Online	289.00
09/30/17	IHCA	September Training	TCM	Various	Online	27.50
09/30/17	CE Solutions	Various	Various	Various	Online	358.59
10/31/17	Picc Me Vascular Solutions	Central Line Class	LTC Staff	Clinical		350.00
10/31/17	TCM	Nursing Care Center Manual	Various	Various		343.30
10/18/18	A. Garcia	Kinesio Taping Training	A. Garcia	Therapy		549.00
10/18/17	J. Thomas	Kinesio Taping Training	J. Thomas	Therapy		549.00
10/31/17	J. Lee Chung	Seminar	J. Lee Chung			100.00
10/31/17	C. Santora	Kinesio Taping Training	C. Santora	Therapy		549.00
10/31/17	CE Solutions	Various	Various	Various	Online	358.59
11/12/17	Nancy Hartman	PCC Training	Various	Various	Webinar	1,022.00
11/30/17	TCM	TG Indeed Conf.				562.86
11/30/17	Picc Me Vascular Solutions	Central Line Class	LTC Staff	Clinical		700.00
11/30/17	CE Solutions	Various	Various	Various	Online	358.59
12/31/17	TCM	PIC Confrence				1,028.70
12/31/17	CE Solutions	Various	Various	Various	Online	59.78
					Totals	15,261.80

Transitional Care of Arlington Heights
0053561
Travel Schedule
1/1/17-12/31/2017

DATE	EMPLOYE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILEAGE	ADJ	TOTAL	ADJ
1/11/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	320.76		320.76	
1/11/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	188.24		188.24	
1/11/2017	L.Henderson	Marketing	Hospital	Marketing	326.65	-326.65	0	ADJ
1/25/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	281.41		281.41	
2/8/2017	M. Lauer	Nurse Liason	Hospital	Case Mgmt	574.75		574.75	
2/8/2017	L. Henderso	Marketing	Hospital	Marketing	422.07	-422.07	0	ADJ
2/8/2017	M. Valera	Nurse Liason	Hospital	Case Mgmt	180.17		180.17	
2/22/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	228.32		228.32	
2/28/2017	MILEAGE RE	TCM Manager	TCAH	Meetings/Work	176.63		176.63	
2/28/2017	MILEAGE RE	TCM Manager	TCAH	Meetings/Work	286.52		286.52	
3/7/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	220.83		220.83	
3/22/2017	M. Lauer	Nurse Liason	Hospital	Case Mgmt	549.27		549.27	
3/22/2017	M. Valera	Nurse Liason	Hospital	Case Mgmt	248.65		248.65	
3/31/2017	OC, KD AND	TCM Manager	TCAH	Meetings/Work	254.18		254.18	
4/5/2017	M. Valera	Nurse Liason	Hospital	Case Mgmt	294.13		294.13	
4/5/2017	M. Lauer	Nurse Liason	Hospital	Case Mgmt	556.72		556.72	
4/19/2017	M. Valera	Nurse Liason	Hospital	Case Mgmt	177.49		177.49	
4/30/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	200.26		200.26	
4/30/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	584.76		584.76	
4/30/2017	L.Henderson	Marketing	Hospital	Marketing	224.49	-224.49	0	ADJ
4/30/2017	MILEAGE	TCM Manager	TCAH	Meetings/Work	282.48		282.48	
5/17/2017	M. Valera	Nurse Liason	Hospital	Case Mgmt	100.79		100.79	
5/31/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	133.65		133.65	
5/31/2017	KD MILEAGE	TCM Manager	TCAH	Meetings/Work	154.08		154.08	
5/31/2017	OC MAY 201	TCM Manager	TCAH	Meetings/Work	256.8		256.8	
6/14/2017	S. Walker	Activities	Conf.	Conference	7.66		7.66	
6/14/2017	M. Valera	Nurse Liason	Hospital	Case Mgmt	110.39		110.39	
6/14/2017	M. Lauer	Nurse Liason	Hospital	Case Mgmt	866.02		866.02	
6/28/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	157.7		157.7	
6/30/2017	AP AND OC	TCM Manager	TCAH	Meetings/Work	146.75		146.75	
7/31/2017	KD/AP JULY	TCM Manager	TCAH	Meetings/Work	254.42		254.42	
7/12/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	618.32		618.32	
7/12/2017	S.Walker	Activities	Conf.	Conference	9.43		9.43	
7/12/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	145.14		145.14	
7/26/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	153.7		153.7	
7/31/2017	OLIVIA C'S J	TCM Manager	TCAH	Meetings/Work	116.1		116.1	
8/9/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	153.7		153.7	
8/9/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	232.75		232.75	
8/9/2017	L.Henderson	Marketing	Hospital	Marketing	1,014.15	-1014.15	0	ADJ
8/9/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	636.88		636.88	
8/9/2017	B.Montes				16.26	-16.26	0	ADJ
8/23/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	231.01		231.01	
8/23/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	159.58		159.58	
8/31/2017	K DEMPSEY	TCM Manager	TCAH	Meetings/Work	115.56		115.56	
8/31/2017	O CHRISTIA	TCM Manager	TCAH	Meetings/Work	77.04		77.04	
9/6/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	181.92		181.92	
9/6/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	156.12		156.12	
9/20/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	226.02		226.02	
9/20/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	172.75		172.75	
9/20/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	548.11		548.11	
9/30/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	134.27		134.27	
9/30/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	208.52		208.52	
9/30/2017	O CHRISTIA	TCM Manager	TCAH	Meetings/Work	77.04		77.04	
10/31/2017	AP MILEAGE	TCM Manager	TCAH	Meetings/Work	22.19		22.19	
10/31/2017	OC MILEAGE	TCM Manager	TCAH	Meetings/Work	154.08		154.08	
10/18/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	199.81		199.81	
10/18/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	584.11		584.11	
10/18/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	165.73		165.73	
10/31/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	296.8		296.8	
10/31/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	201.55		201.55	
11/15/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	115.24		115.24	
11/15/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	157.7		157.7	
11/15/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	530		530	
11/29/2017	K.Baldazo	Dietician	Conf.	Conference	242.87		242.87	
11/29/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	125.4		125.4	
11/29/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	159.85		159.85	
11/30/2017	OC, TG AND	TCM Manager	TCAH	Meetings/Work	317.1		317.1	
12/31/2017	OC MILEAGE	TCM Manager	TCAH	Meetings/Work	168.48		168.48	
12/13/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	211.49		211.49	
12/13/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	165.74		165.74	
12/13/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	589.89		589.89	
12/27/2017	L.Henderson	Marketing	Hospital	Marketing	80.14	-80.14	0	ADJ
12/27/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	171.1		171.1	
12/31/2017	S.Walker	Activities	Conf.	Conference	5.74		5.74	
12/31/2017	L.Reinecke	Nurse Liason	Hospital	Case Mgmt	381.65		381.65	
12/31/2017	M.Valera	Nurse Liason	Hospital	Case Mgmt	137.84		137.84	
12/31/2017	M.Lauer	Nurse Liason	Hospital	Case Mgmt	406.2		406.2	
				Totals	**19742.11**	**-2083.76**	**17658.35**	

Transitional Care of Arlington Heights
0053561
Legal Schedule
1/1/17-12/31/2017

DATE	G/L ACCT	PAYEE/VENDOR	AMOUNT	ADJ	Total
11/1/2016	80550	Much Shellist	107.00	-107	-
11/1/2016	80550	Much Shellist	128.50	-128.5	-
1/31/2017	80650	Much Shellist	110		110.00
2/28/2017	80550	Stone McGuire	5,497.50		5,497.50
1/31/2017	80550	Much Shellist	5,005.00		5,005.00
2/28/2017	80550	Much Shellist	1,025.00		1,025.00
1/31/2017	80550	Much Shellist	89.39		89.39
1/31/2017	80550	Much Shellist	275.00		275.00
5/31/2017	80550	Much Shellist	785.39		785.39
10/3/2017	80550	Much Shellist	869.95		869.95
11/14/2017	80550	Much Shellist	1,076.16		1,076.16
		Totals	**14,968.89**	**(235.50)**	**14,733.39**

Facility Name & ID Number **Transitional Care of Arlington Heights** **#** **0053561** **Report Period Beginning:** **1/1/2017** **Ending:** **12/31/2017**

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 political 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? **N/A**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **121,233**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,203** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,203**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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 of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees