FOR BHF USE

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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	PROPRIETARY	GOVERNMENTAL
[ ] 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	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 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

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler Telephone Number: (847) 374-0400
Email Address:

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: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	101	1,141	26,021	27,263	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	101	1,141	26,021	27,263	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.24%

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 120 and days of care provided 20,099

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: 1/1/2018 Ending: 12/31/2018

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	482,859	42,797		525,656		525,656		525,656			1
2	Food Purchase		275,167		275,167		275,167	(15,280)	259,887			2
3	Housekeeping	196,458	48,002	41,792	286,252		286,252		286,252			3
4	Laundry		20,676		20,676		20,676		20,676			4
5	Heat and Other Utilities			159,190	159,190		159,190		159,190			5
6	Maintenance	64,986		116,407	181,393		181,393		181,393			6
7	Other (specify):*											7
8	TOTAL General Services	744,303	386,642	317,389	1,448,334		1,448,334	(15,280)	1,433,054			8
	B. Health Care and Programs											
9	Medical Director			27,500	27,500		27,500		27,500			9
10	Nursing and Medical Records	3,754,776	248,653	87,700	4,091,129		4,091,129		4,091,129			10
10a	Therapy	16,980			16,980		16,980		16,980			10a
11	Activities	85,317	1,068		86,385		86,385		86,385			11
12	Social Services	168,627			168,627		168,627		168,627			12
13	CNA Training											13
14	Program Transportation			3,637	3,637		3,637		3,637			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,025,700	249,721	118,837	4,394,258		4,394,258		4,394,258			16
	C. General Administration											
17	Administrative	142,641		425,162	567,803		567,803		567,803			17
18	Directors Fees											18
19	Professional Services			182,706	182,706		182,706		182,706			19
20	Dues, Fees, Subscriptions & Promotions			257,736	257,736		257,736	(89,922)	167,814			20
21	Clerical & General Office Expenses	605,198	252,502	170,104	1,027,804		1,027,804	(234,006)	793,798			21
22	Employee Benefits & Payroll Taxes			1,711,622	1,711,622		1,711,622		1,711,622			22
23	Inservice Training & Education											23
24	Travel and Seminar			29,250	29,250		29,250	(1,861)	27,389			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			239,902	239,902		239,902	149,243	389,145			26
27	Other (specify):*											27
28	TOTAL General Administration	747,839	252,502	3,016,482	4,016,823		4,016,823	(176,546)	3,840,277			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,517,842	888,865	3,452,708	9,859,415		9,859,415	(191,826)	9,667,589			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: 1/1/2018 Ending: 12/31/2018

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			14,633	14,633		14,633	547,489	562,122			30
31	Amortization of Pre-Op. & Org.			29,528	29,528		29,528	14,650	44,178			31
32	Interest			87,512	87,512		87,512	659,810	747,322			32
33	Real Estate Taxes			454,564	454,564		454,564	347,078	801,642			33
34	Rent-Facility & Grounds			1,306,146	1,306,146		1,306,146	(1,306,146)				34
35	Rent-Equipment & Vehicles			22,299	22,299		22,299		22,299			35
36	Other (specify):*											36
37	TOTAL Ownership			1,914,682	1,914,682		1,914,682	262,881	2,177,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,480,474	1,345,991	516,047	4,342,512		4,342,512		4,342,512			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,514	109,514		109,514		109,514			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	2,480,474	1,345,991	625,561	4,452,026		4,452,026		4,452,026			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,998,316	2,234,856	5,992,951	16,226,123		16,226,123	71,055	16,297,178			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: 1/1/2018 Ending: 12/31/2018

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	(279,189)	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	(105,795)	21		24
25	Fund Raising, Advertising and Promotional	(49,621)	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	(188,050)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (622,655)		$	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)	693,710		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 693,710		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 71,055		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: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank/Credit Card Fees	$ (28,205)	21	1
2	Non-Allowable Interest	(2,397)	32	2
3	Marketing Director Wages	(98,739)	21	3
4	Marketing Consultant	(35,433)	20	4
5	Dietary Offset	(15,280)	2	5
6	Non-Allowable Travel and Entertainment	(267)	21	6
7	Non-Allowable IHCA Dues	(2,868)	20	7
8	Non-Allowable Donations	(1,000)	21	8
9	Non-Allowable LOC Fees	(2,000)	20	9
10	Non-Allowable Seminar Expense	(200)	24	10
11	Adjust Out of State Travel	(1,661)	24	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**	(188,050)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,280)	0	0	0	0	0	0	0	0	0	0	(15,280)	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**	(15,280)	0	0	0	0	0	0	0	0	0	0	(15,280)	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	(89,922)	0	0	0	0	0	0	0	0	0	0	(89,922)	20
21	Clerical & General Office Expenses	(234,006)	0	0	0	0	0	0	0	0	0	0	(234,006)	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	(1,861)	0	0	0	0	0	0	0	0	0	0	(1,861)	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	149,243	0	0	0	0	0	0	0	0	0	149,243	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(325,789)	149,243	0	0	0	0	0	0	0	0	0	(176,546)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(341,069)	149,243	0	0	0	0	0	0	0	0	0	(191,826)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(279,189)	826,678	0	0	0	0	0	0	0	0	0	547,489	30
31	Amortization of Pre-Op. & Org.	0	14,650	0	0	0	0	0	0	0	0	0	14,650	31
32	Interest	(2,397)	662,207	0	0	0	0	0	0	0	0	0	659,810	32
33	Real Estate Taxes	0	347,078	0	0	0	0	0	0	0	0	0	347,078	33
34	Rent-Facility & Grounds	0	(1,306,146)	0	0	0	0	0	0	0	0	0	(1,306,146)	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	(281,586)	544,467	0	0	0	0	0	0	0	0	0	262,881	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)	(622,655)	693,710	0	0	0	0	0	0	0	0	0	71,055	45

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	$ 1,306,146			$	$ (1,306,146)	1
2	V	30	Depreciation Expense				826,678	826,678	2
3	V	31	Amortization Expense				14,650	14,650	3
4	V	33	Real Estate Taxes	454,564			801,642	347,078	4
5	V	26	Insurance				149,243	149,243	5
6	V	32	Interst Expense				662,207	662,207	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,760,710			$ 2,454,420	$ * 693,710	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: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 1/1/2018 Ending: 2/31/2018

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: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	HUD Mortgage			$	$ 19,418,033			$ 650,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Due to Landlord	X		Working Capital				4,952,142				6
7	Capital Funding		X	LOC				882,176			87,512	7
8	Due to Others/ST Notes	X		Working Capital				100,000				8
9	TOTAL Facility Related						$	$ 25,352,351			$ 737,512	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,397)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,397)	14
15	TOTALS (line 9+line14)						$	$ 25,352,351			$ 735,115	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description		Amount	Line
1	1. Real Estate Tax accrual used on 2017 report.	$		1
2	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.)	$	255,642	2
3	3. Under or (over) accrual (line 2 minus line 1).	$	255,642	3
4	4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	546,000	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	801,642	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2013		8
2014		9
2015	212,780	10
2016	296,951	11
2017	544,216	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Bulding Partnership R/E Tax Accrual =544216 x 1.003= 546000 (rounded)

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.

2017 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 2017 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 2017.

	(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.	$ 544,215.58	$ 544,215.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 544,215.58	$ 544,215.58

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

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: 1/1/2018 Ending: 12/31/2018

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	$ 1,424,772	4
5			2016	2016	732,364		39	18,779	18,779	37,558	5
6											6
7											7
8											8
	Improvement Type**										
9	Facility Generator Repair			2017	6,052		20	303	303	454	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	Building Partnership Depreciation					963,075			(963,075)		34
35											35
36	Book Depreciation					14,633					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: 1/1/2018 Ending: 12/31/2018

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	$ 977,708		$ 494,005	$ (469,070)	$ 1,462,784	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: 1/1/2018 Ending: 12/31/2018

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	$ 2,045,135	$	$ 204,514	$ 204,514	10	$ 613,621	71
72	Current Year Purchases	5,800				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,050,935	$	$ 204,514	$ 204,514		$ 613,621	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)	$ 23,430,523	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 977,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 698,519	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (279,189)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,076,404	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 Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 22,299 Description: Copier/Fax Equioment 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: 1/1/2018 Ending: 12/31/2018

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		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	$ 973,125		$	$		$ 973,125	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	125,346					125,346	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	1,348,584					1,348,584	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				1,275,587		1,275,587	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): O2 Therapy Supplies	39-2					70,404		70,404	12
13	Other (specify): Lab/Xray/Equipment	39-3				516,047			516,047	13
14	TOTAL			$ 2,447,055		$ 516,047	$ 1,345,991		$ 4,309,093	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ (15,285)	$ (13,607)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (223,796))	1,220,988	1,221,003	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	170,115	170,115	6
7	Other Prepaid Expenses	24,231	73,526	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		1,835,202	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,400,049	$ 3,286,239	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	77,773	2,045,836	16
17	Accumulated Depreciation (book methods)	(34,718)	(2,495,757)	17
18	Deferred Charges	41,129	41,129	18
19	Organization & Pre-Operating Costs	88,585	674,588	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(66,439)	(105,506)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		5,052,143	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 107,524	$ 26,083,898	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,507,573	$ 29,370,137	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 939,552	$ 943,552	26
27	Officer's Accounts Payable		212,530	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	325,645	325,645	30
31	Accrued Taxes Payable (excluding real estate taxes)		546,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		55,117	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	98,041	98,041	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,363,238	$ 2,180,885	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,171,115	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	5,934,318	5,934,318	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,934,318	$ 25,105,433	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,297,556	$ 27,286,318	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,789,983)	$ 2,083,819	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,507,573	$ 29,370,137	48

*(See instructions.)

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Current Assets		Operating	After Consolidation
9	Debt Service Reserve Escrow		1,108,693
	Replacement Reserve Escrow		556,421
	Taxes & Insurance Escrow		170,088
		-	1,835,202

Long-Term Assets		Amount	
23	Due From Tenant	-	4,952,143
	Due From Tenant		100,000
		-	5,052,143

Current Liabilities		Amount	
36	Due BCBS	97,090	97,090
	Accrued 401K	951	951
		98,041	98,041

Other Long Term Liabilities		Amount	
43	Due To Landlord	4,952,142	4,952,142
	LOC Cap Funding	882,176	882,176
	Due to Other	100,000	100,000
		5,934,318	5,934,318

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,818,391)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,818,393)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(971,590)	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)**	$ (971,590)	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)**	$ (5,789,983)	24 *

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

Facility Name & ID Number Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 12,261,350	1
2	Discounts and Allowances for all Levels	(10,541,274)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,720,076	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,287,765	6
7	Oxygen	55,920	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,343,685	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	2,424	13
14	Non-Patient Meals	15,280	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,250	16
17	Sale of Drugs	2,554,911	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	283,348	19
20	Radiology and X-Ray	144,952	20
21	Other Medical Services	182,210	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,188,375	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,397	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,397	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,254,533	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,448,334	31
32	Health Care	4,394,258	32
33	General Administration	4,016,823	33
	B. Capital Expense		
34	Ownership	1,914,682	34
	C. Ancillary Expense		
35	Special Cost Centers	4,342,512	35
36	Provider Participation Fee	109,514	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,226,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	(971,590)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (971,590)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 18,712	44
45	Private Pay - Net Inpatient Revenue	402,337	45
46	Medicare - Net Inpatient Revenue	1,348,093	46
47	Other-(specify) Managed Care	(52,875)	47
48	Other-(specify) MMAI A/B	3,809	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,720,076	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: 1/1/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,505	2,576	$ 98,834	$ 38.37	1
2	Assistant Director of Nursing	4,961	5,395	211,142	39.14	2
3	Registered Nurses	53,905	57,310	1,986,006	34.65	3
4	Licensed Practical Nurses	12,559	13,488	388,258	28.79	4
5	CNAs & Orderlies	50,186	53,717	794,029	14.78	5
6	CNA Trainees					6
7	Licensed Therapist	75,044	79,620	2,480,476	31.15	7
8	Rehab/Therapy Aides	1,755	1,875	16,980	9.06	8
9	Activity Director	2,124	2,330	37,208	15.97	9
10	Activity Assistants	3,051	3,308	48,109	14.54	10
11	Social Service Workers	5,867	6,128	168,627	27.52	11
12	Dietician	2,375	2,640	77,172	29.23	12
13	Food Service Supervisor	3,733	4,074	61,367	15.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,179	26,866	344,320	12.82	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,080	64,986	31.24	17
18	Housekeepers	15,778	16,748	196,458	11.73	18
19	Laundry					19
20	Administrator	1,312	1,413	103,680	73.38	20
21	Assistant Administrator	1,454	1,636	38,961	23.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,595	22,541	840,004	37.27	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	1,359	1,427	41,699	29.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	285,702	305,172	$ 7,998,316 *	$ 26.21	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	27,500	9-3	36
37	Medical Records Consultant	Monthly	16,765	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	25,624	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 69,889		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	401	$ 28,381	10-3	50
51	Licensed Practical Nurses	97	5,320	10-3	51
52	Certified Nurse Assistants/Aides	530	11,610	10-3	52
53	TOTAL (lines 50 - 52)	1,028	$ 45,311		53

Facility Name & ID Number: Transitional Care of Arlington Heights # 0053561 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Rachel Mabe (1/1/18-1/9/18)	Administrator	0	$	2,556
Maureen Kruhl (1/10/18-8/17/18)	Administrator	0		62,492
Michelle Stuercke	Administrator	0		38,632
Ashley Davis	Asst. Administrator	0		38,961
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	142,641

B. Administrative - Other

Description		Amount
Management Fee	$	425,162
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	425,162

C. Professional Services

Vendor/Payee	Type		Amount
ADP/Paycom	Payroll Processing	$	81,206
FGMK, LLC	Accounting/Consulting		27,903
Marcum	Accounting/Audit		19,231
Pinnacle Quality Insight	Customer Satisfaction Survey		2,880
MIS Choice	IT Services		3,060
Nancy Hartmann	PCC Consulting		1,176
Stone McGuire	Compliance Program		16,902
Phigenics, LLC	Water Survey		5,550
Much Shellist	Legal		24,798
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	182,706

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	136,599
Unemployment Compensation Insurance		
FICA Taxes		703,709
Employee Health Insurance		821,966
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
401K Expense		6,688
Uniform Expense		12,707
Pre-Employee Screening		13,112
Employee Welfare		15,605
Holiday Expense		1,236
TOTAL (agree to Schedule V, line 22, col.8)	$	1,711,622

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

Description	Line #		Amount
		$	
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	3,980
Advertising: Employee Recruitment		123,808
Health Care Worker Background Check		
(Indicate # of checks performed)		
Patient Background Checks 146		14,547
Licenses		2,120
Marketing		85,054
Dues & Subscriptions		23,359
Less: Public Relations Expense		( )
Non-allowable advertising		(85,054)
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)	$	167,814

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		14,689
Seminar Expense		12,700
Entertainment Expense		( )
TOTAL (agree to Sch. V, line 24, col. 8)	$	27,389

**See instructions.

Transitional Care of Arlington Heights
0053561
Seminar Schedule
1/1/18-12/31/2018

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
02/01/18	J. Chikani	Cardiac CEU	J Chickani		Online	330.00	
02/07/18	S. Janlowiak	Kinesio Training	S. Janlowiak		Online	648.00	
01/31/18	CE Solutions	Various	Various		Online	298.83	
01/31/18	TCM	Behavioral Interviewing			Online	72.50	
02/28/18	CE Solutions	Various	Various		Online	298.83	
03/31/18	CE Solutions	Various	Various		Online	553.83	
04/18/18	L. Cussen	Kinesio Training	L. Cussen		Online	548.00	
04/18/18	L. Reinecke	Transforum Training	L. Reinecke			138.00	
04/30/18	CE Solutions	Various	Various		Online	553.83	
05/21/18	JCM Institute, INC	CPR Class	**Various**		Arlington Heights	800.00	
05/16/18	A. Miller	Trends in Joint Replacement	A. Miller			209.99	
05/31/18	CE Solutions	Various	Various		Online	553.83	
05/31/18	PICC Me Vascular Solutions	Vascular	Various		Online	350.00	
05/31/18	TCM	Indeed Conference	Various		Austin, TX	199.50	ADJ
06/19/18	JCM Institute, INC	CPR Class	Various		***Arlington Heights***	400.00	
07/11/18	Leading Age, Inc.	Leading Age Expo	M. Krahl		Schaumburg	749.00	
06/30/18	CE Solutions	Various	Various		Online	553.83	
07/31/18	PICC Me Vascular Solutions	Vascular	Various		Online	350.00	
07/31/18	CE Solutions	Various	Various		Online	553.83	
08/09/18	M. King	Activity Course	M. King	Activity Director	Online	459.00	
08/09/18	F. Sanchez	Dietary Credentialling	F. Sanchez	Dietary Manager	Online	399.00	
08/31/18	PICC Me Vascular Solutions	Vascular	Various		Online	350.00	
08/31/18	TCM	MDS Webinar	Various	MDS	Online	60.00	
08/31/18	CE Solutions	Various	Various		Online	553.83	
09/20/18	M. King	Activity Course	M. King	Activity Director	Online	87.01	
09/30/18	PICC Me Vascular Solutions	Vascular	Various		Online	350.00	
09/30/18	CE Solutions	Various	Various		Online	431.64	
10/31/18	PICC Me Vascular Solutions	Vascular	Various		Online	350.00	
10/31/18	TCM	Moving Mountains	Various		Online	27.50	
10/31/18	TCM	AHCA Webinar	Various		Online	32.50	
10/31/18	CE Solutions	Various	Various		Online	431.64	
11/05/18	Kurtz Ambulance Svc, Inc.	AHA BLS for Healthcare	Various		Arlington Heights	400.00	
11/30/18	CE Solutions	Various	Various		Online	431.64	
12/31/18	TCM	Section GG Webinar	Various		Online	64.50	
12/31/18	CE Solutions	Various	Various		Online	309.44	
						12,899.50	
						-199.5	
					Total	12700	

Transitional Care of Arlington Heights
0053561
Travel Schedule
1/1/18-12/31/2018

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	MILAGE	AIRFARE	HOTEL	TOTAL
Jan	Various	Various	Hospital/Seminar	Various	588.27			588.27
Feb	Various	Various	Hospital/Seminar	Various	1950.74			1,950.74
Mar	Various	Various	Hospital/Seminar	Various	1760			1,760.00
Apr	Various	Various	Hospital/Seminar	Various	1710.4	506.41		2,216.81
May	Various	Various	Hospital/Seminar	Various	1076.2			1,076.20
Jun	Various	Various	Hospital/Seminar	Various	950.98			950.98
Jul	Various	Various	Hospital/Seminar	Various	52.32			52.32
Aug	Various	Various	Hospital/Seminar	Various	2024.35			2,024.35
Sep	Various	Various	Hospital/Seminar	Various	1197.85	408.96	745.6	2,352.41
Oct	Various	Various	Hospital/Seminar	Various	530.33			530.33
Nov	Various	Various	Hospital/Seminar	Various	1653.35			1,653.35
Dec	Various	Various	Hospital/Seminar	Various	1194.3			1,194.30
						TOTAL Travel		16,350.06
						ADJ Out of state Travel		(1,660.97)
					14689.09	915.37	745.6	14,689.09

Transitional Care of Arlington Heights
0053561
Legal Schedule
1/1/18-12/31/2018

DATE	G/L ACCT. #	PAYEE/VENDOR	Services	AMOUNT
1/16/2018	80550.00	Much Sellist	Legal Services	552.72
2/6/2018	80550.00	Much Sellist	Legal Services	150.74
1/31/2018	80550.00	Much Sellist	Legal Services	367.25
2/1/2018	80550.00	Much Sellist	Legal Services	593.25
2/28/2018	80550.00	Much Sellist	Legal Services	452
3/16/2018	80550.00	Much Sellist	Legal Services	195
4/30/2018	80550.00	Much Sellist	Legal Services	139.41
4/30/2018	80550.00	Much Sellist	Legal Services	339
4/30/2018	80550.00	Much Sellist	Legal Services	226
5/31/2018	80550.00	Much Sellist	Legal Services	508.5
3/31/2018	80550.00	Much Sellist	Legal Services	11594.25
6/30/2018	80550.00	Much Sellist	Legal Services	3901
7/31/2018	80550.00	Much Sellist	Legal Services	1412.5
7/31/2018	80550.00	Much Sellist	Legal Services	113
8/13/2018	80550.00	Much Sellist	Legal Services	1076.5
8/31/2018	80550.00	Much Sellist	Legal Services	1469
8/31/2018	80550.00	Much Sellist	Legal Services	734.5
8/31/2018	80550.00	Much Sellist	Legal Services	226
9/30/2018	80550.00	Much Sellist	Legal Services	452
11/12/2018	80550.00	Much Sellist	Legal Services	295
		TOTAL:		24797.62

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $6660**

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

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

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

(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. $ **109,514**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **15,280**

(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