FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: Healthbridge Arlington Hts

Address: 1200 N Arlington Hts (Number) Arlington Hgts (City) 60004 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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: Kathy Mallonee **Telephone Number:** 314-480-1259
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 1/1/20 to 12/31/20 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) Sheila Weeks
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Kathy Mallonee, Healthcare Consulting Senior
(Firm Name & Address) Mueller Prost LC, 7733 Forsyth Boulevard, Suite 1200, St. Louis,MO 63105
(Telephone) 314-480-1259 Fax # 314-889-8759

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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 _____

	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	43,920	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	43,920	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	29	1,689	18,866	20,584	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29	1,689	18,866	20,584	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.87%

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 01/16/2016

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/16/2016 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 14,074

Medicare Intermediary National Government Services, Inc.

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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	383,026	55,065		438,091		438,091		438,091			1
2	Food Purchase		225,794		225,794		225,794	(2,004)	223,790			2
3	Housekeeping	192,433	34,743	13,662	240,838		240,838		240,838			3
4	Laundry		12,739		12,739		12,739		12,739			4
5	Heat and Other Utilities			104,183	104,183		104,183		104,183			5
6	Maintenance	62,576		159,110	221,686		221,686	(42,384)	179,302			6
7	Other (specify):*											7
8	**TOTAL General Services**	638,035	328,341	276,955	1,243,331		1,243,331	(44,388)	1,198,943			8
	B. Health Care and Programs											
9	Medical Director			12,125	12,125		12,125		12,125			9
10	Nursing and Medical Records	3,436,380	264,881	582,645	4,283,906		4,283,906		4,283,906			10
10a	Therapy	1,720,822	4,614	150,547	1,875,983		1,875,983		1,875,983			10a
11	Activities	119,916	1,216	1,145	122,277		122,277	(1,145)	121,132			11
12	Social Services	167,657			167,657		167,657		167,657			12
13	CNA Training											13
14	Program Transportation			3,219	3,219		3,219		3,219			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,444,775	270,711	749,681	6,465,167		6,465,167	(1,145)	6,464,022			16
	C. General Administration											
17	Administrative	223,825		85,635	309,460		309,460		309,460			17
18	Directors Fees											18
19	Professional Services			122,278	122,278		122,278		122,278			19
20	Dues, Fees, Subscriptions & Promotions			215,053	215,053		215,053	(118,796)	96,257			20
21	Clerical & General Office Expenses	503,695	10,396	347,392	861,483		861,483	(346,139)	515,344			21
22	Employee Benefits & Payroll Taxes			1,260,781	1,260,781		1,260,781	(34,779)	1,226,002			22
23	Inservice Training & Education											23
24	Travel and Seminar			20,963	20,963		20,963	(11,597)	9,366			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			189,727	189,727		189,727	144,330	334,057			26
27	Other (specify):*											27
28	**TOTAL General Administration**	727,520	10,396	2,241,829	2,979,745		2,979,745	(366,981)	2,612,764			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,810,330	609,448	3,268,465	10,688,243		10,688,243	(412,514)	10,275,729			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 Healthbridge Arlington Hts #0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			21,864	21,864		21,864	472,141	494,005			30
31	Amortization of Pre-Op. & Org.							14,652	14,652			31
32	Interest			41,656	41,656		41,656	642,549	684,205			32
33	Real Estate Taxes			892,193	892,193		892,193	(424,782)	467,411			33
34	Rent-Facility & Grounds			1,502,161	1,502,161		1,502,161	(1,502,161)	0			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,457,874	2,457,874		2,457,874	(797,601)	1,660,273			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		866,827	656,384	1,523,211		1,523,211		1,523,211			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,887	104,887		104,887		104,887			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		866,827	761,271	1,628,098		1,628,098		1,628,098			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,810,330	1,476,275	6,487,610	14,774,215		14,774,215	(1,210,115)	13,564,100			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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(2,004)	2		4
5	Telephone, TV & Radio in Resident Rooms	(42,384)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(176,582)	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	(1,145)	11		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	(72,979)	21		24
25	Fund Raising, Advertising and Promotional	(118,796)	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	(320,075)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (733,965)		$	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)	(476,150)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (476,150)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,210,115)		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

Healthbridge Arlington Hts

ID# 0053561

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Interest Income / Expenses	$ (539)	32	1
2	Misc./Other Income	(8,323)	21	2
3	Cable Television	(178,662)	21	3
4	Employee/Guest Meals	(23,462)	22	4
5	Transportation and Travel	0	24	5
6	Out of State Seminar	(11,597)	24	6
7	Wages - Nurse Liaison	(86,175)	21	7
8	Nurse Liason - Employee Benefits	(11,317)	22	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(320,075)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Healthbridge Arlington Hts **#** 0053561 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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	(2,004)	0	0	0	0	0	0	0	0	0	0	(2,004)	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	(42,384)	0	0	0	0	0	0	0	0	0	0	(42,384)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(44,388)	0	0	0	0	0	0	0	0	0	0	(44,388)	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	(1,145)	0	0	0	0	0	0	0	0	0	0	(1,145)	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**	(1,145)	0	0	0	0	0	0	0	0	0	0	(1,145)	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	(118,796)	0	0	0	0	0	0	0	0	0	0	(118,796)	20
21	Clerical & General Office Expenses	(346,139)	0	0	0	0	0	0	0	0	0	0	(346,139)	21
22	Employee Benefits & Payroll Taxes	(34,779)	0	0	0	0	0	0	0	0	0	0	(34,779)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(11,597)	0	0	0	0	0	0	0	0	0	0	(11,597)	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	144,330	0	0	0	0	0	0	0	0	0	144,330	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(511,311)	144,330	0	0	0	0	0	0	0	0	0	(366,981)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(556,844)	144,330	0	0	0	0	0	0	0	0	0	(412,514)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Healthbridge Arlington Hts # 0053561 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(176,582)	648,723	0	0	0	0	0	0	0	0	0	472,141	30
31	Amortization of Pre-Op. & Org.	0	14,652	0	0	0	0	0	0	0	0	0	14,652	31
32	Interest	(539)	643,088	0	0	0	0	0	0	0	0	0	642,549	32
33	Real Estate Taxes	0	(424,782)	0	0	0	0	0	0	0	0	0	(424,782)	33
34	Rent-Facility & Grounds	0	(1,502,161)	0	0	0	0	0	0	0	0	0	(1,502,161)	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**	(177,121)	(620,480)	0	0	0	0	0	0	0	0	0	(797,601)	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)**	(733,965)	(476,150)	0	0	0	0	0	0	0	0	0	(1,210,115)	45

Facility Name & ID Number Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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%			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	$ 1,502,161			$	$ (1,502,161)	1
2	V	30	Depreciation Expense				648,723	648,723	2
3	V	31	Amortization Expense				14,652	14,652	3
4	V	33	Real Estate Taxes	892,193			467,411	(424,782)	4
5	V	26	Insurance				144,330	144,330	5
6	V	32	Interest Expense				643,088	643,088	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,394,354			$ 1,918,204	$ * (476,150)	14

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

Facility Name & ID Number Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column 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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			$	$ 18,651,011			$ 647,669	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Due To/From Landlord	X		Working Capital				707,416				6
7	Line of Credit - Cap Funding		X	LOC				387,322			41,656	7
8	Due To/From HBSC/PPP/HHS	X		Working Capital				3,514,941				8
9	TOTAL Facility Related						$	$ 23,260,690			$ 689,325	9
	B. Non-Facility Related*											
10	Interest Income		X								(539)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (539)	14
15	TOTALS (line 9+line14)						$	$ 23,260,690			$ 688,786	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* 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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 552,337	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.)		$ 812,111	2
3. Under or (over) accrual (line 2 minus line 1).		$ 259,774	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 814,547	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.		$ 1,074,321	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	212,780	8
	2016	296,951	9
	2017	544,216	10
	2018	552,337	11
	2019	814,547	12

Bulding Partnership R/E Tax Accrual =812111x 1.003= 814547

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Healthbridge Arlington Hts 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 2019 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 2019.

	(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.	$ 812,111.00	$ 812,111.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 812,111.00	$ 812,111.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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: 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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 2,374,620	4
5			2016	2016	732,364		39	18,779	18,779	75,116	5
6											6
7											7
8											8
	Improvement Type**										
9	Facility Generator Repair			2017	6,052		20	303	303	1,060	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	Landlord Depreciation					648,723			(648,723)		34
35											35
36	Book Depreciation					21,864					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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 670,587		$ 494,006	$ (154,717)	$ 2,450,796	70

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

Facility Name & ID Number Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 2,050,935	$	$ 204,514	$ 204,514	10	$ 1,022,649	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,050,935	$	$ 204,514	$ 204,514		$ 1,022,649	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)	$ 670,587	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 698,520	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 27,933	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,473,445	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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ Description:
(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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-1	15395	hrs	$ 653,040		$	$	15,395	$ 653,040	1
2	Licensed Speech and Language Development Therapist	10a-1	20911	hrs	145,943				20,911	145,943	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-1	6658	hrs	921,839				6,658	921,839	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				842,942		842,942	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): O2 Therapy Supplies	39-2						23,885		23,885	12
13	Other (specify): Lab/Xray/Equipment	39-3						656,384		656,384	13
14	TOTAL				$ 1,720,822		$	$ 1,523,211	42,964	$ 3,244,033	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.

Transitional Care of Arlington Heights
IDPH License Number: 0053561
Page 17 Supporting Document
FYE: 12/31/2020

Account No.	Description	Amount	Reclassification	Net Amount	SCH	LINE	Col
23000	Accrued Expenses	51,311.99	0.00	51,311.99	PG17	36	1
24100	Refunds due BCBS	(0.29)	0.00	(0.29)	PG17	36	1
				51,311.70			
20150	USB Credit Card	21,700.40	0.00	21,700.40	PG17	37	1
20600	Flexible Spending Account	(0.13)	0.00	(0.13)	PG17	37	1
				21,700.27			
25000	Due To/From Landlord	707,416.54	0.00	707,416.54	PG17	43	1
25100	Line of Credit - Cap Funding	387,322.68	0.00	387,322.68	PG17	43	1
25050	Due To/From HBSC	902,694.32	0.00	902,694.32	PG17	43	1
25300	GSB SBA PPP Loan/Grant	1,395,803.00	0.00	1,395,803.00	PG17	43	1
25400	HHS (Cares) Funding	1,216,443.67	0.00	1,216,443.67	PG17	43	1
26100	Due To/From Other	0.00	0.00	0.00	PG17	43	1
				4,609,680.21			

Facility Name & ID Number Healthbridge Arlington Hts # 0053561 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 422,699	$ 2,222,480	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,937,872	1,937,872	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,722	86,722	6
7	Other Prepaid Expenses	42,959	90,855	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,490,252	$ 4,337,929	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		18,751,134	14
15	Leasehold Improvements, at Historical Cost	2,220	2,220	15
16	Equipment, at Historical Cost	117,576	2,112,113	16
17	Accumulated Depreciation (book methods)	(71,503)	(3,964,387)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	88,585	704,276	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(88,585)	(156,956)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		357,267	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 48,293	$ 19,924,803	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,538,545	$ 24,262,732	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,175,598	$ 1,175,598	26
27	Officer's Accounts Payable		312,530	27
28	Accounts Payable-Patient Deposits	1,992	1,992	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	340,924	340,924	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,715	225,015	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		53,622	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	51,312	51,312	36
37	See attached	21,700	21,700	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,601,241	$ 2,182,693	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,651,010	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached	4,609,680	4,609,680	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,609,680	$ 23,260,690	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,210,921	$ 25,443,383	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,672,376)	$ (1,180,651)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,538,545	$ 24,262,732	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,487,518)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,487,518)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,184,857)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,184,857)	17	
	B. Transfers (Itemize):			
18	**Rounding**	(1)	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,672,376)	24	*

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

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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	$ 9,255,804	1
2	Discounts and Allowances for all Levels	(5,543,564)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,712,241	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,455,373	6
7	Oxygen	16,562	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,471,935	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	958	13
14	Non-Patient Meals	2,004	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,593,035	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	447,127	19
20	Radiology and X-Ray	148,950	20
21	Other Medical Services	203,815	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,395,888	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	539	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 539	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Private Duty Revenue	432	28
28a	Misc. Income	8,323	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,755	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,589,358	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,243,331	31
32	Health Care	6,465,167	32
33	General Administration	2,979,745	33
	B. Capital Expense		
34	Ownership	2,457,874	34
	C. Ancillary Expense		
35	Special Cost Centers	1,523,211	35
36	Provider Participation Fee	104,887	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,774,215	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,184,857)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,184,857)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (177,930)	44
45	Private Pay - Net Inpatient Revenue	603,792	45
46	Medicare - Net Inpatient Revenue	2,550,645	46
47	Other-(specify) Managed Care	736,162	47
48	Other-(specify) MMAI A/B	(429)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,712,240	49

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

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

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

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

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,507	1,507	$ 121,711	$ 80.74	1
2	Assistant Director of Nursing	2,904	2,904	113,670	39.14	2
3	Registered Nurses	41,005	41,005	1,971,580	48.08	3
4	Licensed Practical Nurses	14,779	14,779	489,573	33.13	4
5	CNAs & Orderlies	40,536	40,536	681,701	16.82	5
6	CNA Trainees			0		6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides	42,963	42,963	1,717,894	39.99	8
9	Activity Director	1,549	1,549	38,270	24.71	9
10	Activity Assistants	6,093	6,093	81,646	13.40	10
11	Social Service Workers	6,162	6,162	167,657	27.21	11
12	Dietician	2,012	2,012	53,292	26.49	12
13	Food Service Supervisor	3,829	3,829	76,570	20.00	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	16,878	16,878	253,164	15.00	15
16	Dishwashers			0		16
17	Maintenance Workers	2,080	2,080	62,576	30.08	17
18	Housekeepers	13,182	13,182	192,433	14.60	18
19	Laundry			0		19
20	Administrator	2,633	2,633	207,448	78.79	20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical	17,618	17,618	520,072	29.52	24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified MR Prof. (QMRP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records	2,585	2,585	61,073	23.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,315	218,315	$ 6,810,330 *	$ 31.20	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	757	40,121	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Housekeeping	604	13,662	3-3	47
48					48
49	TOTAL (lines 35 - 48)	1,361	$ 53,783		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,053	$ 90,924	10-3	50
51	Licensed Practical Nurses	1,127	75,742	10-3	51
52	Certified Nurse Assistants/Aides	4,790	192,551	10-3	52
53	TOTAL (lines 50 - 52)	6,970	$ 359,217		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Matalvo	Asst Administrator	0	$ 4,808
Sheila Weeks	Administrator	0	175,227
Leonard Koenig	Administrator	0	43,790
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 223,825

B. Administrative - Other

Description	Amount
Staffing Management Expenses	$ 7,840
Payroll Processing	77,795
TOTAL (agree to Schedule V, line 17, col. 3)	$ 85,635
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mueller Prost	Billing Services, Accounting,	$ 58,754
Pinnacle Quality Insight	Customer Satisfaction	3,041
Onshift Inc	Scheduling	6,240
FGMK LLC	Tax Return Preparation	7,474
Marcum LLP	Reviewed financial statements	12,638
MIS Choice Inc.	Email & Phone Services	1,265
Vivra LLC	Potential Name Change	10,300
Vedder Price	Legal Services	12,662
JAMS, Inc	Legal Services	1,100
ProAssurance Specialty Insurance	Legal Services	3,186
FISH Law	Legal Services	5,616
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 122,278

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,579
Unemployment Compensation Insurance	41,895
FICA Taxes	468,687
Employee Health Insurance	51,471
Employee Meals	14,339
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	8,375
Employee Welfare	8,886
Holiday Party	454
Other Employee Benefits	510,317
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,226,002

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	$
Advertising: Employee Recruitment	41,994
Health Care Worker Background Check	
(Indicate # of checks performed 792)	
Patient Background Checks	8,895
License	6,112
Dues & Subscription	39,256
Marketing	116,259
Advertising	2,538
Less: Public Relations Expense	(116,259)
Non-allowable advertising	(2,538)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 96,257

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 11,597
In-State Travel	2,589
Seminar Expense	6,777
Entertainment Expense	(11,597)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,366

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $7920**

(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? **Yes**

(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. $ **104,887**
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. $ **2,004**

(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 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.