



Facility Name & ID Number ARBOR VIEW NURSING & REHAB CTR

# 0047118 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	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	116	Skilled (SNF)	116	42,340	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	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,725	803	2,905	7,433	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	19,446	4,700		24,146	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,171	5,503	2,905	31,579	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.58%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 04/01/05

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/05 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 116 and days of care provided 2,905

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number ARBOR VIEW NURSING & REHAB CTR # 0047118 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	171,704	16,440	7,067	195,211		195,211		195,211		1
2	Food Purchase		163,810		163,810	(10,052)	153,758	(397)	153,361		2
3	Housekeeping	100,127	23,251		123,378		123,378		123,378		3
4	Laundry	43,408	18,848	3,893	66,149		66,149		66,149		4
5	Heat and Other Utilities			152,664	152,664		152,664	1,484	154,148		5
6	Maintenance	24,412	17,238	38,433	80,083		80,083	7,067	87,150		6
7	Other (specify):*			31,569	31,569		31,569		31,569		7
8	<b>TOTAL General Services</b>	339,651	239,587	233,626	812,864	(10,052)	802,812	8,154	810,966		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			17,250	17,250		17,250		17,250		9
10	Nursing and Medical Records	1,766,210	93,258	29,988	1,889,456		1,889,456		1,889,456		10
10a	Therapy	2,289		819	3,108		3,108		3,108		10a
11	Activities	75,826	2,100		77,926		77,926		77,926		11
12	Social Services	31,169		8,793	39,962		39,962		39,962		12
13	CNA Training										13
14	Program Transportation			3,602	3,602		3,602		3,602		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,875,494	95,358	60,452	2,031,304		2,031,304		2,031,304		16
	<b>C. General Administration</b>										
17	Administrative	89,283			89,283		89,283	93,476	182,759		17
18	Directors Fees										18
19	Professional Services			49,664	49,664		49,664	(8,401)	41,263		19
20	Dues, Fees, Subscriptions & Promotions			28,660	28,660		28,660	(8,329)	20,331		20
21	Clerical & General Office Expenses	110,755	19,440	57,537	187,732		187,732	(27,922)	159,810		21
22	Employee Benefits & Payroll Taxes			359,065	359,065	10,052	369,117		369,117		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,527	1,527		1,527	1,017	2,544		24
25	Other Admin. Staff Transportation			7,704	7,704		7,704	928	8,632		25
26	Insurance-Prop.Liab.Malpractice			96,434	96,434		96,434	2,733	99,167		26
27	Other (specify):*			59,636	59,636		59,636	(37,183)	22,453		27
28	<b>TOTAL General Administration</b>	200,038	19,440	660,227	879,705	10,052	889,757	16,319	906,076		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,415,183	354,385	954,305	3,723,873		3,723,873	24,473	3,748,346		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	7,067
	REPAIRS & MAINTENANCE	0
		0
		7,067
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	3,893
		0
		3,893
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	25,575
	ELECTRICITY	78,465
	WATER	47,892
	CABLE TV - LOBBY	732
		0
		152,664
<b>6</b>	<b>MAINTENANCE</b>	
	GROUND MAINTENANCE	7,179
	PAINTING & DECORATING	937
	BUILDING REPAIRS	5,098
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,027
	ELEVATOR MAINTENANCE & REPAIR	2,769
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,653
	FIRE SERVICE	5,770
		0
		0
		0
		0
		38,433
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	31,569
	SECURITY SERVICE	0
		0
		0
		31,569
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	17,250
		17,250

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	11,652
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,924
	PHARMACY CONSULTANT XVIII B 39-2	2,417
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	9,720
	RESPIRATORY	192
	LPN CONSULTANT	1,083
		29,988
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	819
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		819
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	8,793
		0
		8,793
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	3,602
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	10,479
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	39,185
		0
		49,664
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	9,031
	EMPLOYEE WANT ADS XIX F	1,388
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	10,731
	LICENSES & PERMITS XIX F	2,917
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,540
	PATIENT BACKGROUND CHECKS XIX F	2,053
		28,660
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,084
	EQUIPMENT REPAIR & MAINTENANCE	1,141
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	676
	HOME OFFICE EXPENSE	36,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,636
	MESSENGER SERVICE	0
		0
		57,537

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	183,220
	UNEMPLOYMENT COMPENSATION XIX D	58,817
	WORKERS COMPENSATION INSURANC XIX D	86,823
	HOSPITALIZATION INSURANCE XIX D	18,763
	EMPLOYEE BENEFITS - OTHER XIX D	6,774
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	4,668
	CHICAGO HEAD TAX XIX D	0
		0
		359,065
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,527
	TRAVEL XIX G	0
		1,527
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	7,704
		7,704
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	96,434
		96,434
27	<b>OTHER</b>	
	BAD DEBTS VI 24	59,636
		59,636

GRAND TOTAL COLUMN 3 OTHER

954,305

**ARBOR VIEW NURSING & REHAB CTR  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	163,810
LESS SALES TAX	<u>(397)</u>
NET FOOD	163,413

TOTAL PATIENT CENSUS	31,579
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	94,737

ADD # EMPLOYEE MEALS/DAY	17
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	6,205

PATIENT MEALS	94,737
ADD EMPLOYEE MEALS	<u>6,205</u>
TOTAL MEALS/YEAR	100,942

NET FOOD	163,413
DIVIDE TOTAL MEALS/YEAR	<u>100,942</u>

COST PER MEAL	1.62
TIME EMPLOYEE MEALS	<u>6,205</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>10,052</b>

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Facility Name & ID Number **ARBOR VIEW NURSING & REHAB CTR**

#0047118

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			7,557	7,557		7,557	(1,478)	6,079			30
31	Amortization of Pre-Op. & Org.			8,193	8,193		8,193		8,193			31
32	Interest			71,827	71,827		71,827	(6,095)	65,732			32
33	Real Estate Taxes			84,465	84,465		84,465	1,399	85,864			33
34	Rent-Facility & Grounds			348,576	348,576		348,576		348,576			34
35	Rent-Equipment & Vehicles			54,359	54,359		54,359		54,359			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			574,977	574,977		574,977	(6,174)	568,803			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,465	321,055	429,520		429,520		429,520			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		108,465	384,565	493,030		493,030		493,030			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,415,183	462,850	1,913,847	4,791,880		4,791,880	18,299	4,810,179			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(2,702)	30		9
10	Interest and Other Investment Income	(7,655)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(397)	2		13
14	Non-Care Related Interest	(1,583)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(676)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,636)	27		24
25	Fund Raising, Advertising and Promotional	(9,031)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(36,253)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (117,933)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	136,232		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 136,232</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 18,299</b>		<b>37</b>

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

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

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

ARBOR VIEW NURSING & REHAB CTR

ID# 0047118

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	STAFF TRANSPORTATION MARKETING	\$ (1,020)	25	1
2				2
3	MARKETING SALARY	(26,233)	21	3
4	PROF FEES - HEALTHCARE HORIZONS	(9,000)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	<b>Total</b>	(36,253)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number ARBOR VIEW NURSING & REHAB CTR# 0047118

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(397)	0	0	0	0	0	0	0	0	0	0	(397)	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	1,484	0	0	0	0	0	0	0	0	0	1,484	5
6	Maintenance	0	7,067	0	0	0	0	0	0	0	0	0	7,067	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(397)</b>	<b>8,551</b>	<b>0</b>	<b>8,154</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	93,476	0	0	0	0	0	0	0	0	0	93,476	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,000)	599	0	0	0	0	0	0	0	0	0	(8,401)	19
20	Fees, Subscriptions & Promotions	(9,031)	702	0	0	0	0	0	0	0	0	0	(8,329)	20
21	Clerical & General Office Expenses	(26,909)	(1,013)	0	0	0	0	0	0	0	0	0	(27,922)	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	0	1,017	0	0	0	0	0	0	0	0	0	1,017	24
25	Other Admin. Staff Transportation	(1,020)	1,948	0	0	0	0	0	0	0	0	0	928	25
26	Insurance-Prop.Liab.Malpractice	0	2,733	0	0	0	0	0	0	0	0	0	2,733	26
27	Other (specify):*	(59,636)	22,453	0	0	0	0	0	0	0	0	0	(37,183)	27
28	<b>TOTAL General Administration</b>	<b>(105,596)</b>	<b>121,915</b>	<b>0</b>	<b>16,319</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(105,993)</b>	<b>130,466</b>	<b>0</b>	<b>24,473</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ARBOR VIEW NURSING & REHAB CTR # 0047118 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,702)	0	1,224	0	0	0	0	0	0	0	0	(1,478)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,238)	0	3,143	0	0	0	0	0	0	0	0	(6,095)	32
33	Real Estate Taxes	0	0	1,399	0	0	0	0	0	0	0	0	1,399	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>(11,940)</b>	<b>0</b>	<b>5,766</b>	<b>0</b>	<b>(6,174)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(117,933)</b>	<b>130,466</b>	<b>5,766</b>	<b>0</b>	<b>18,299</b>	<b>45</b>							

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT HEDGES	50			HI CARE		MANAGEMENT
		SEE ATTACHED SCHEDULE		MANAGEMENT	SPRINGFIELD	
WILLIAM IRVINE	50			HI PROPERTIES	SPRINGFIELD	REAL ESTATE
				HEALTHCARE	SPRINGFIELD	NURSING
				HORIZONS		CONSULTING

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17		HI CARE MANAGEMENT				1
2	V	21	36,000				(36,000)	2
3	V	5				1,484	1,484	3
4	V	6				7,067	7,067	4
5	V	17				93,476	93,476	5
6	V	19				599	599	6
7	V	20				702	702	7
8	V	21				34,987	34,987	8
9	V	24				1,017	1,017	9
10	V	25				1,948	1,948	10
11	V	26				2,733	2,733	11
12	V	27				22,453	22,453	12
13	V							13
14	Total		\$ 36,000			\$ 166,466	\$ * 130,466	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 DEPRECIATION	\$	H& I PROPERTIES - HOME OFFICE		\$ 1,224	\$	1,224	15
16	V	32 INTEREST				3,143		3,143	16
17	V	33 REAL ESTATE TAXES				1,399		1,399	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 5,766	\$ *	5,766	39

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

Facility Name & ID Number ARBOR VIEW NURSING & REHAB CTR # 0047118 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00		SEE	ATTACHED	SALARY	\$ 28,232	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$165,000										2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00		SEE	ATTACHED	SALARY	28,232	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$165,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING				SEE	ATTACHED	SALARY	2,472	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$14,446										8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR				SEE	ATTACHED	SALARY	12,458	17-7	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$72,810										11
12											12
13								TOTAL	\$ 71,394		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 ARBOR VIEW NURSING & REHAB CTR # 0047118 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization HI CARE MANAGEMENT  
 Street Address 1625 SOUTH 6TH STREET  
 City / State / Zip Code SPRINGFIELD, IL. 62703  
 Phone Number ( 217 )528-004  
 Fax Number ( 217 )528-0412

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PER RESIDENT DAY	184,560	7	\$ 8,675	\$ 31,579	\$ 1,484	1	
2	6	MAINTENANCE	PER RESIDENT DAY	184,560	7	41,300	37,474	31,579	7,067	2
3	17	OFFICER SALARY-B HEDGES	PER RESIDENT DAY	184,560	7	165,000	165,000	31,579	28,232	3
4	17	OFFICER SALARY-B. IRVINE	PER RESIDENT DAY	184,560	7	165,000	165,000	31,579	28,232	4
5	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,560	7	69,647	69,647	31,579	11,917	5
6	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,560	7	73,854	73,854	31,579	12,637	6
7	17	SPECIAL PROJ MNGR-DEREK	PER RESIDENT DAY	184,560	7	72,810	72,810	31,579	12,458	7
8	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,560	7	3,500		31,579	599	8
9	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	184,560	7	4,105		31,579	702	9
10	21	OFFICE EXPENSE	PER RESIDENT DAY	184,560	7	204,479	141,575	31,579	34,987	10
11	24	TRAVEL & SEMINARS	PER RESIDENT DAY	184,560	7	5,945		31,579	1,017	11
12	25	TRANSPORTATION	PER RESIDENT DAY	184,560	7	11,383		31,579	1,948	12
13	26	INSURANCE	PER RESIDENT DAY	184,560	7	15,972		31,579	2,733	13
14	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	184,560	7	131,223		31,579	22,453	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 972,893	\$ 725,360		\$ 166,466	25

Facility Name & ID Number ARBOR VIEW NURSING & REHAB CTR

# 0047118

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization H & I PROPERTIES - HOME OFFICE  
 Street Address 1625 S SIXTH STREET  
 City / State / Zip Code SPRINGFIELD,IL. 62703  
 Phone Number ( 217 )528-0044  
 Fax Number ( 217 )528-0412

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	639	7	\$ 6,741	\$	116	\$ 1,224	1
2	32	INTEREST	639	7	17,316		116	3,143	2
3	33	REAL ESTATE	639	7	7,709		116	1,399	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				\$ 31,766	\$		\$ 5,766	25

Facility Name &amp; ID Number

ARBOR VIEW NURSING &amp; REHAB CTR

# 0047118

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$	1					
2	US BANK (HI PROP)		X	MORTGAGE (OFFICE)		6/29/05						2					
3								47,943	6/29/12	0.0635	3,143	3					
4												4					
5												5					
	<b>Working Capital</b>																
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		598,288	REVOLV	PRIME+	52,731	6					
7	Z. KARKOMI			WORKING CAPITAL	INTEREST		337,000	337,000	DEMAND		17,513	7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 337,000	\$ 983,231			\$ 73,387	9					
	<b>B. Non-Facility Related*</b>																
10											1,583	10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 1,583	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 337,000	\$ 983,231			\$ 74,970	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2006 report.	\$	<b>81,152</b>	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.)	\$	<b>82,806</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>1,654</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>82,811</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>84,465</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	_____	8
	2003	_____	9
	2004	<b>86,824</b>	10
	2005	<b>81,152</b>	11
	2006	<b>82,806</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ARBOR VIEW NURSING & REHAB CTR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0047118

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-21-300-020</u>	<u>NURSING HOME</u>	\$ <u>82,805.70</u>	\$ <u>82,805.70</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>82,805.70</u>	\$ <u>82,805.70</u>

**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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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: 31,890 B. General Construction Type: Exterior MASONRY/BRICK Frame \_\_\_\_\_ Number of Stories 2 FLOORS & BASEMENT

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

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

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

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: 8,193 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	<u>HOME OFFICE</u>		<u>2005</u>	<u>\$ 10,498</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 10,498</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1973	\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	FIRE SAFETY CODE WORK		2005	7,995	291	27.5	291		682	9
10	SECURITY SYSTEM		2005	7,934	288	27.5	288		675	10
11	WATER HEATER		2005	5,600	204	27.5	204		478	11
12	DOOR ALARM SYSTEM		2005	2,200	80	27.5	80		188	12
13	SIGN		2005	1,756	64	27.5	64		150	13
14	INTERIOR RAILS		2006	5,484	200	27.5	200		358	14
15	FIRESTOPPING		2006	7,959	289	27.5	289		518	15
16	CHECK VALVE		2006	3,465	126	27.5	126		131	16
17	PUMP		2007	15,272	439	27.5	439		439	17
18	FIRE ALARM		2007	12,169	240	27.5	240		240	18
19										19
20	PATIO (FROM LANDLORD)		2007	14,210						20
21										21
22	H & I PROPERTIES		2005	47,709		39			3,397	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

\*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 131,753	\$ 2,221		\$ 2,221	\$	\$ 7,256	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 9,913	\$ 2,364	\$ 991	\$ (1,373)	10 YRS	\$ 2,532	71
72	Current Year Purchases	8,862	1,772	443	(1,329)	10 YRS	443	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 18,775	\$ 4,136	\$ 1,434	\$ (2,702)		\$ 2,975	75

D. Vehicle Depreciation (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				\$ 6,000	\$ 1,200	\$ 1,200	\$	5	\$ 1,200	76
77										77
78										78
79										79
80	TOTALS			\$ 6,000	\$ 1,200	\$ 1,200	\$		\$ 1,200	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)	\$ 167,026	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,557	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,855	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,702)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,431	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: XION LLC

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:		<u>116</u>	<u>04/01/05</u>	\$ <u>348,576</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>116</u>		\$ <u>348,576</u>			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: \_\_\_\_\_\*

**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: \$ 54,359 Description: SEE SCHEDULE ATTACHED

(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

10. Effective dates of current rental agreement:

Beginning 4/01/05

Ending 2/28/14

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

Fiscal Year Ending Annual Rent

12. /2008 \$ 348,575

13. /2009 \$ 348,575

14. /2010 \$ 348,575

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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	39-3	hrs	\$		\$ 152,858	\$		\$ 152,858	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			27,507			27,507	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			140,690			140,690	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 prescripts				108,465		108,465	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 321,055	\$ 108,465		\$ 429,520	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 ARBOR VIEW NURSING & REHAB CTR

# 0047118

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 38,355	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,000 )	1,001,166		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,821		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate	91,910		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,215,252	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	69,834		15
16	Equipment, at Historical Cost	49,354		16
17	Accumulated Depreciation (book methods)	(35,730)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec security deposits)	1,436		22
23	Other(specify): Deposit on fixed asset	808		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 85,702	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,300,954	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,210,409	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	935,288		29
30	Accrued Salaries Payable	86,794		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,498		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,811		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,355,800	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	96,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 96,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,451,800	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,150,846)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,300,954	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(767,233)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>1</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(767,232)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(383,614)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(383,614)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,150,846)</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,271,375	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,271,375	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	129,236	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 129,236	8
	<b>C. Other Operating Revenue</b>		
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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	7,655	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,655	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,408,266	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	812,864	31
32	Health Care	2,031,304	32
33	General Administration	879,705	33
	<b>B. Capital Expense</b>		
34	Ownership	574,977	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	429,520	35
36	Provider Participation Fee	63,510	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,791,880	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(383,614)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (383,614)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* 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 **ARBOR VIEW NURSING & REHAB CTR**

# **0047118**

Report Period Beginning: **01/01/2007**

Ending:

**12/31/2007**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,945	2,185	\$ 74,845	\$ 34.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,465	14,745	424,312	28.78	3
4	Licensed Practical Nurses	19,482	21,586	508,288	23.55	4
5	CNAs & Orderlies	57,727	63,249	652,886	10.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	158	175	2,289	13.08	8
9	Activity Director	1,989	2,241	30,518	13.62	9
10	Activity Assistants	4,527	4,654	45,308	9.74	10
11	Social Service Workers	1,686	1,965	31,169	15.86	11
12	Dietician					12
13	Food Service Supervisor	1,918	2,093	36,575	17.47	13
14	Head Cook	5,362	6,135	58,143	9.48	14
15	Cook Helpers/Assistants	9,131	9,745	76,986	7.90	15
16	Dishwashers					16
17	Maintenance Workers	1,871	2,160	24,412	11.30	17
18	Housekeepers	11,739	13,094	100,127	7.65	18
19	Laundry	5,136	5,667	43,408	7.66	19
20	Administrator	2,119	2,271	89,283	39.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	989	1,122	14,486	12.91	23
24	Clerical	6,166	6,845	96,269	14.06	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	857	976	10,444	10.70	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS &amp; Ward Cle</u>	3,699	4,038	95,435	23.63	33
34	TOTAL (lines 1 - 33)	149,966	164,946	\$ 2,415,183 *	\$ 14.64	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	96	\$ 7,067	1-3	35
36	Medical Director	MONTHLY	17,250	9-3	36
37	Medical Records Consultant	MONTHLY	4,924	10-3	37
38	Nurse Consultant	MONTHLY	9,720	10-3	38
39	Pharmacist Consultant		2,417	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	MONTHLY	8,793	12-3	45
46	Other(specify) <u>LPN CONSULTANT</u>		1,083	10-3	46
47				10-3	47
48					48
49	TOTAL (lines 35 - 48)	96	\$ 51,254		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53





Facility Name &amp; ID Number ARBOR VIEW NURSING &amp; REHAB CTR

# 0047118

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL HEALTHCARE ASSOC.\$7461
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,152 Line 10-2
- (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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,510  
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. \$ 10,052 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
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? YES  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees