

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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.

<p>I. IDPH License ID Number: <u>0047118</u></p> <p>Facility Name: <u>ARBOR VIEW NURSING & REHABILITATION</u></p> <p>Address: <u>1805 27TH STREET</u> <u>ZION</u> <u>60099</u> Number City Zip Code</p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>(217) 528-0044</u> Fax # <u>(217) 528-3412</u></p> <p>HFS ID Number: <u>20-255389601</u></p> <p>Date of Initial License for Current Owners: <u>04/01/2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4" style="width: 20%;">Paid Preparer</td> <td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2"> <p>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</p> </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____		(Title) <u>MEMBER</u>	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	<p>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</p>	
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Facility Name & ID Number ARBOR VIEW NURSING & REHABILITATION

0047118 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	42,456	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	42,456	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	2,798	1,398	2,663	6,859	8
9	SNF/PED					9
10	ICF	20,936	3,064		24,000	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,734	4,462	2,663	30,859	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.68%

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 2,663

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number ARBOR VIEW NURSING & REHABILITATION # 0047118 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
	A. General Services										
1	Dietary	158,480	19,374	7,196	185,050		185,050		185,050		1
2	Food Purchase		154,350		154,350	(3,579)	150,771	(236)	150,535		2
3	Housekeeping	127,701	25,039		152,740		152,740		152,740		3
4	Laundry	50,157	14,060	3,409	67,626		67,626		67,626		4
5	Heat and Other Utilities			151,701	151,701		151,701	1,569	153,270		5
6	Maintenance	30,573	11,519	34,342	76,434		76,434	7,818	84,252		6
7	Other (specify):*			17,300	17,300		17,300	269	17,569		7
8	TOTAL General Services	366,911	224,342	213,948	805,201	(3,579)	801,622	9,420	811,042		8
	B. Health Care and Programs										
9	Medical Director			6,925	6,925		6,925		6,925		9
10	Nursing and Medical Records	1,809,396	100,344	17,730	1,927,470		1,927,470		1,927,470		10
10a	Therapy	54,825	496		55,321		55,321		55,321		10a
11	Activities	70,336	1,668		72,004		72,004		72,004		11
12	Social Services	22,520		7,186	29,706		29,706		29,706		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,957,077	102,508	31,841	2,091,426		2,091,426		2,091,426		16
	C. General Administration										
17	Administrative	73,705			73,705		73,705	105,194	178,899		17
18	Directors Fees										18
19	Professional Services			42,075	42,075		42,075	(5,841)	36,234		19
20	Dues, Fees, Subscriptions & Promotions			34,530	34,530		34,530	(19,403)	15,127		20
21	Clerical & General Office Expenses	126,635	15,022	71,738	213,395		213,395	(28,836)	184,559		21
22	Employee Benefits & Payroll Taxes			341,903	341,903	3,579	345,482		345,482		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,861	2,861		2,861	997	3,858		24
25	Other Admin. Staff Transportation			1,934	1,934		1,934	2,661	4,595		25
26	Insurance-Prop.Liab.Malpractice			94,170	94,170		94,170	2,458	96,628		26
27	Other (specify):*			49,718	49,718		49,718	(24,726)	24,992		27
28	TOTAL General Administration	200,340	15,022	638,929	854,291	3,579	857,870	32,504	890,374		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,524,328	341,872	884,718	3,750,918		3,750,918	41,924	3,792,842		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
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,196
	REPAIRS & MAINTENANCE	0
		0
		7,196
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,409
		0
		3,409
5	HEAT & OTHER UTILITIES	
	GAS HEAT	30,684
	ELECTRICITY	73,125
	WATER	46,925
	CABLE TV - LOBBY	967
		0
		151,701
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,731
	PAINTING & DECORATING	331
	BUILDING REPAIRS	3,615
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	13,433
	ELEVATOR MAINTENANCE & REPAIR	5,377
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,437
	FIRE SERVICE	3,418
		0
		0
		0
		0
		34,342
7	OTHER	
	SCAVENGER	17,300
	SECURITY SERVICE	0
		0
		0
		17,300
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,925
		6,925

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	5,838
	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	2,080
	PHARMACY CONSULTANT XVIII B 39-2	2,637
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	6,600
	RESPIRATORY	575
		0
		17,730
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	101
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	7,085
		0
		7,186
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,668
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	34,407
		0
		42,075
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	17,228
	EMPLOYEE WANT ADS XIX F	1,011
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	9,371
	LICENSES & PERMITS XIX F	1,237
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	443
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,248
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,696
	PATIENT BACKGROUND CHECKS XIX F	1,296
		34,530
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	18,861
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,195
	HOME OFFICE EXPENSE	36,000
	THEFT & DAMAGE LOSS	226
	TELEPHONE	15,456
	MESSENGER SERVICE	0
		0
		71,738

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	191,194
	UNEMPLOYMENT COMPENSATION XIX D	49,811
	WORKERS COMPENSATION INSURANC XIX D	80,425
	HOSPITALIZATION INSURANCE XIX D	12,420
	EMPLOYEE BENEFITS - OTHER XIX D	488
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	7,565
	CHICAGO HEAD TAX XIX D	0
		0
		341,903
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,861
	TRAVEL XIX G	0
		2,861
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,934
		1,934
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	94,170
		94,170
27	OTHER	
	BAD DEBTS VI 24	49,718
		49,718

GRAND TOTAL COLUMN 3 OTHER

884,718

**ARBOR VIEW NURSING & REHABILITATION
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	154,350
LESS SALES TAX	<u>(236)</u>
NET FOOD	154,114

TOTAL PATIENT CENSUS	30,859
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	92,577

ADD # EMPLOYEE MEALS/DAY	6
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	2,196

PATIENT MEALS	92,577
ADD EMPLOYEE MEALS	<u>2,196</u>
TOTAL MEALS/YEAR	94,773

NET FOOD	154,114
DIVIDE TOTAL MEALS/YEAR	<u>94,773</u>

COST PER MEAL	1.63
TIME EMPLOYEE MEALS	<u>2,196</u>
EMPLOYEE MEAL RECLASSIFICATION	3,579

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Facility Name & ID Number

ARBOR VIEW NURSING & REHABILITATION

#0047118

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	
	D. Ownership											
30	Depreciation			11,335	11,335		11,335	(4,238)	7,097			30
31	Amortization of Pre-Op. & Org.			2,048	2,048		2,048		2,048			31
32	Interest			62,766	62,766		62,766	(2,598)	60,168			32
33	Real Estate Taxes			80,173	80,173		80,173	1,391	81,564			33
34	Rent-Facility & Grounds			348,576	348,576		348,576		348,576			34
35	Rent-Equipment & Vehicles			97,690	97,690		97,690		97,690			35
36	Other (specify):*											36
37	TOTAL Ownership			602,588	602,588		602,588	(5,445)	597,143			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,130	301,150	393,280		393,280		393,280			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,684	63,684		63,684		63,684			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		92,130	364,834	456,964		456,964		456,964			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,524,328	434,002	1,852,140	4,810,470		4,810,470	36,479	4,846,949			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,462)	30		9
10	Interest and Other Investment Income	(5,660)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(236)	2		13
14	Non-Care Related Interest		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	(1,195)	21		18
19	Entertainment		20		19
20	Contributions	(2,248)	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	(49,718)	27		24
25	Fund Raising, Advertising and Promotional	(17,228)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(443)	20		28
29	Other-Attach Schedule	(35,135)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (117,325)		\$	30

BHF USE ONLY							
48		49		50		51	

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	
		Amount	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)	153,804		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 153,804		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 36,479		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	2	3	4	
		Yes	No	Amount	Reference	
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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ARBOR VIEW NURSING & REHABILITATION

ID# 0047118

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2			2
3	MARKETING SALARY	(26,135)	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	Total	(35,135)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ARBOR VIEW NURSING & REHABILITATION# 0047118

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(236)	0	0	0	0	0	0	0	0	0	0	(236)	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	1,569	0	0	0	0	0	0	0	0	0	1,569	5
6	Maintenance	0	7,818	0	0	0	0	0	0	0	0	0	7,818	6
7	Other (specify):*	0	269	0	0	0	0	0	0	0	0	0	269	7
8	TOTAL General Services	(236)	9,656	0	9,420	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	105,194	0	0	0	0	0	0	0	0	0	105,194	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,000)	3,159	0	0	0	0	0	0	0	0	0	(5,841)	19
20	Fees, Subscriptions & Promotions	(19,919)	516	0	0	0	0	0	0	0	0	0	(19,403)	20
21	Clerical & General Office Expenses	(27,330)	(1,506)	0	0	0	0	0	0	0	0	0	(28,836)	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	997	0	0	0	0	0	0	0	0	0	997	24
25	Other Admin. Staff Transportation	0	2,661	0	0	0	0	0	0	0	0	0	2,661	25
26	Insurance-Prop.Liab.Malpractice	0	2,458	0	0	0	0	0	0	0	0	0	2,458	26
27	Other (specify):*	(49,718)	24,992	0	0	0	0	0	0	0	0	0	(24,726)	27
28	TOTAL General Administration	(105,967)	138,471	0	32,504	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,203)	148,127	0	41,924	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ARBOR VIEW NURSING & REHABILITATION # 0047118 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,462)	0	1,224	0	0	0	0	0	0	0	0	(4,238)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,660)	0	3,062	0	0	0	0	0	0	0	0	(2,598)	32
33	Real Estate Taxes	0	0	1,391	0	0	0	0	0	0	0	0	1,391	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	TOTAL Ownership	(11,122)	0	5,677	0	(5,445)	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)	(117,325)	148,127	5,677	0	36,479	45							

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	SEE ATTACHED SCHEDULE		HI CARE		
				MANAGEMENT	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	50			HI PROPERTIES	SPRINGFIELD	REAL ESTATE
				HEALTHCARE		NURSING
				HORIZONS	SPRINGFIELD	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		" " "		1,569	1,569	3
4	V	6		" " "		7,818	7,818	4
5	V	7		" " "		269	269	5
6	V	17		" " "		105,194	105,194	6
7	V	19		" " "		3,159	3,159	7
8	V	20		" " "		516	516	8
9	V	21		" " "		34,494	34,494	9
10	V	24		" " "		997	997	10
11	V	25		" " "		2,661	2,661	11
12	V	26		" " "		2,458	2,458	12
13	V	27		" " "		24,992	24,992	13
14	Total		\$ 36,000			\$ 184,127	\$ * 148,127	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		" " " "		3,062	3,062	16
17	V	33 REAL ESTATE TAXES		" " " "		1,391	1,391	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		\$			\$ 5,677	\$ * 5,677	39

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

Facility Name & ID Number ARBOR VIEW NURSING & REHABILITA # 0047118 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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				SALARY	\$ 32,989	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00			SEE	SALARY	32,989	17-7	4
5							ATTACHED				5
6							SCHEDULE				6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	2,444	17-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	12,922	17-7	10
11											11
12											12
13								TOTAL	\$ 81,344		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 & REHABILITATION # 0047118 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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	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	5	UTILITIES	PER RESIDENT DAY	182,408	7	\$ 9,275	30,859	\$ 1,569	1	
2	6	MAINTENANCE	PER RESIDENT DAY	182,408	7	46,214	38,650	30,859	7,818	
3	7	SCAVENGER & EXTERMIN.	PER RESIDENT DAY	182,408	7	1,592	30,859		269	
4	17	OFFICER SALARY	PER RESIDENT DAY	182,408	7	195,000	195,000	30,859	32,989	
5	17	OFFICER SALARY	PER RESIDENT DAY	182,408	7	195,000	195,000	30,859	32,989	
6	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	182,408	7	71,673	71,673	30,859	12,125	
7	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	182,408	7	83,756	83,756	30,859	14,169	
8	17	SPECIAL PROJ MNGR	PER RESIDENT DAY	182,408	7	76,385	76,385	30,859	12,922	
9	19	PROFESSIONAL FEES	PER RESIDENT DAY	182,408	7	18,671		30,859	3,159	
10	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	182,408	7	3,048		30,859	516	
11	21	OFFICE EXPENSE	PER RESIDENT DAY	182,408	7	203,894	145,953	30,859	34,494	
12	24	TRAVEL & SEMINARS	PER RESIDENT DAY	182,408	7	5,891		30,859	997	
13	25	TRANSPORTATION	PER RESIDENT DAY	182,408	7	15,730		30,859	2,661	
14	26	INSURANCE	PER RESIDENT DAY	182,408	7	14,528		30,859	2,458	
15	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	182,408	7	147,729		30,859	24,992	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,088,386	\$ 806,417		\$ 184,127	25

Facility Name & ID Number ARBOR VIEW NURSING & REHABILITATION # 0047118 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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 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

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	16,870		116	3,062	2
3	33	REAL ESTATE	639	7	7,664		116	1,391	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				\$ 31,275	\$		\$ 5,677	25

Facility Name & ID Number

ARBOR VIEW NURSING & REHABILITA'

0047118

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3	US BANK (HI PROP)	X	MORTGAGE (OFFICE)		6/29/05		46,509	6/29/12	0.0635	3,062										
4																				
5																				
Working Capital																				
6	COLE TAYLOR	X	WORKING CAPITAL	INT	REVOL		744,411	REVOLV	PRIME +	37,621										
7																				
8	Z. KARKOMI		WORKING CAPITAL				500,000	DEMAND		25,145										
9	TOTAL Facility Related						1,290,920			65,828										
B. Non-Facility Related*																				
10	IRS, IDR, ETC	X	LATE FEES																	
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)						1,290,920			65,828										

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 2007 report.		\$	82,811	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.)		\$	81,492	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,319)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	81,492	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.		\$	80,173	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004	86,824	9
	2005	81,152	10
	2006	82,806	11
	2007	81,492	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ARBOR VIEW NURSING & REHABILITATION 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 2007 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 2007.

(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>81,491.69</u>	\$ <u>81,491.69</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>81,491.69</u>	\$ <u>81,491.69</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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: 2,048 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>	1
2					2
3	TOTALS			\$ 10,498	3

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	FIRE SAFETY CODE WORK		2005	7,995	291	27.5	291		973
10	SECURITY SYSTEM		2005	7,934	288	27.5	288		963
11	WATER HEATER		2005	5,600	204	27.5	204		682
12	DOOR ALARM SYSTEM		2005	2,200	80	27.5	80		268
13	SIGN		2005	1,756	64	27.5	64		214
14	INTERIOR RAILS		2006	5,484	200	27.5	200		558
15	FIRESTOPPING		2006	7,959	289	27.5	289		807
16	CHECK VALVE		2006	3,465	126	27.5	126		257
17	PUMP		2007	15,272	555	27.5	555		994
18	FIRE ALARM		2007	12,169	443	27.5	443		683
19	FIRE SUPPRESSION SYSTEM UPGRADE		2008	2,993	41	27.5	41		41
20									
21	PATIO (FROM LANDLORD)		2007	14,210					
22									
23	H & I PROPERTIES		2005	47,700	1,224	39	1,224		4,621
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 134,737	\$ 3,805		\$ 3,805	\$	\$ 11,061

**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	\$ 18,775	\$ 4,254	\$ 1,877	\$ (2,377)		\$ 4,852	71
72	Current Year Purchases	4,299	2,580	215	(2,365)		215	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 23,074	\$ 6,834	\$ 2,092	\$ (4,742)		\$ 5,067	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	\$ 1,920	\$ 1,200	\$ (720)	5	\$ 2,400	76
77										77
78										78
79										79
80	TOTALS			\$ 6,000	\$ 1,920	\$ 1,200	\$ (720)		\$ 2,400	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)	\$ 174,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,559	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,097	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,462)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,528	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: \$ 97,690 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. /2009 \$ 348,575

13. /2010 \$ 348,575

14. /2011 \$ _____

* 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$		\$ 139,431	\$		\$ 139,431	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			41,407			41,407	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			120,312			120,312	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				92,130		92,130	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 301,150	\$ 92,130		\$ 393,280	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 & REHABILITATION

0047118

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,728	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 75,000)	1,494,930		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,488		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>real estate escrow deposit</u>	95,474		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,690,620	\$	10
	B. Long-Term Assets			
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	72,827		15
16	Equipment, at Historical Cost	53,653		16
17	Accumulated Depreciation (book methods)	(49,113)		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 (specify):			22
23	Other(specify): <u>security deposits</u>	1,436		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 78,803	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,769,423	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,155,813	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,244,411		29
30	Accrued Salaries Payable	90,644		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,603		31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,492		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>OTHER LOANS</u>	612,800		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,224,763	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>MEMBER LOAN</u>	96,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 96,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,320,763	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,551,340)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,769,423	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,150,846)	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,150,849)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(400,491)	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)	\$ (400,491)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,551,340)	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,316,739	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,316,739	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	87,580	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 87,580	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,660	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,660	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,409,979	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	805,201	31
32	Health Care	2,091,426	32
33	General Administration	854,291	33
	B. Capital Expense		
34	Ownership	602,588	34
	C. Ancillary Expense		
35	Special Cost Centers	393,280	35
36	Provider Participation Fee	63,684	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,810,470	40
41	Income before Income Taxes (line 30 minus line 40)**	(400,491)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (400,491)	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 & REHABILITATION**

0047118

Report Period Beginning: **01/01/2008**

Ending:

12/31/2008

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	1,604	1,676	\$ 59,874	\$ 35.72	1
2	Assistant Director of Nursing	1,504	1,646	53,753	32.66	2
3	Registered Nurses	14,878	15,458	450,525	29.15	3
4	Licensed Practical Nurses	18,850	20,115	476,717	23.70	4
5	CNAs & Orderlies	61,818	66,672	684,221	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,501	4,085	54,825	13.42	8
9	Activity Director	1,893	2,206	30,235	13.71	9
10	Activity Assistants	3,540	3,782	40,101	10.60	10
11	Social Service Workers	1,426	1,675	22,520	13.44	11
12	Dietician					12
13	Food Service Supervisor	2,070	2,217	30,461	13.74	13
14	Head Cook	4,679	5,525	53,070	9.61	14
15	Cook Helpers/Assistants	8,748	9,308	74,949	8.05	15
16	Dishwashers					16
17	Maintenance Workers	2,126	2,409	30,573	12.69	17
18	Housekeepers	13,642	14,252	127,701	8.96	18
19	Laundry	6,009	6,435	50,157	7.79	19
20	Administrator	1,861	2,032	73,705	36.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,949	2,097	26,538	12.66	23
24	Clerical	6,871	7,388	100,097	13.55	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					31
32	Other Health C: <u>MDS</u>	2,588	2,855	84,306	29.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,557	171,833	\$ 2,524,328 *	\$ 14.69	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	103	\$ 7,196	1-3	35
36	Medical Director	monthly	6,925	9-3	36
37	Medical Records Consultant	monthly	2,080	10-3	37
38	Nurse Consultant	monthly	6,600	10-3	38
39	Pharmacist Consultant	monthly	2,637	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		7,085	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	103	\$ 32,523		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 & ID Number ARBOR VIEW NURSING & REHABILITATION

0047118

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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. \$ 7,493.60
- (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? _____
- (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. \$ 11,214 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. \$ 63,684
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. \$ 3,579 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