

Facility Name & ID Number The Arbor

0019471 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,816</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,888</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>144</u>	TOTALS	<u>144</u>	<u>52,704</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF			<u>2,215</u>	<u>2,215</u>	8
9	SNF/PED					9
10	ICF	<u>28,787</u>	<u>8,330</u>		<u>37,117</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,787</u>	<u>8,330</u>	<u>2,215</u>	<u>39,332</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.63%

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)

Meals on Wheels

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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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 08/06/1975

J. Was the facility purchased or leased after January 1, 1978?
 YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 14 and days of care provided 2,215

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/08 Ending: 12/31/08

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
	A. General Services										
1	Dietary	239,846	35,293	7,724	282,863		282,863	282,863			1
2	Food Purchase		227,185		227,185		227,185	227,185			2
3	Housekeeping		20,226	247,237	267,463		267,463	267,463			3
4	Laundry		2,851		2,851		2,851	2,851			4
5	Heat and Other Utilities			142,456	142,456		142,456	142,456			5
6	Maintenance		17,504	61,902	79,406		79,406	79,406			6
7	Other (specify):*										7
8	TOTAL General Services	239,846	303,059	459,319	1,002,224		1,002,224	1,002,224			8
	B. Health Care and Programs										
9	Medical Director			11,250	11,250		11,250	11,250			9
10	Nursing and Medical Records	2,045,095	169,992	229,990	2,445,077		2,445,077	2,445,077			10
10a	Therapy			273,550	273,550		273,550	273,550			10a
11	Activities	102,638	4,500	1,272	108,410		108,410	108,410			11
12	Social Services	44,473		2,178	46,651		46,651	46,651			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,192,206	174,492	518,240	2,884,938		2,884,938	2,884,938			16
	C. General Administration										
17	Administrative	191,522			191,522		191,522	191,522			17
18	Directors Fees			30,000	30,000		30,000	30,000			18
19	Professional Services			89,619	89,619		89,619	89,619			19
20	Dues, Fees, Subscriptions & Promotions			31,195	31,195		31,195	(691)	30,504		20
21	Clerical & General Office Expenses	138,028	24,776	23,064	185,868		185,868	185,868			21
22	Employee Benefits & Payroll Taxes			367,882	367,882		367,882	367,882			22
23	Inservice Training & Education			1,321	1,321		1,321	(500)	821		23
24	Travel and Seminar			2,653	2,653		2,653	(1,898)	755		24
25	Other Admin. Staff Transportation							2,398	2,398		25
26	Insurance-Prop.Liab.Malpractice			90,509	90,509		90,509	90,509			26
27	Other (specify):*										27
28	TOTAL General Administration	329,550	24,776	636,243	990,569		990,569	(691)	989,878		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,761,602	502,327	1,613,802	4,877,731		4,877,731	(691)	4,877,040		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

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#0019471

Report Period Beginning:

01/01/08

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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			38,143	38,143		38,143	84,859	123,002			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,874	67,874		67,874	267,207	335,081			32
33	Real Estate Taxes							54,211	54,211			33
34	Rent-Facility & Grounds			551,880	551,880		551,880	(551,880)				34
35	Rent-Equipment & Vehicles							8,293	8,293			35
36	Other (specify):* MIP Insurance							26,766	26,766			36
37	TOTAL Ownership			657,897	657,897		657,897	(110,544)	547,353			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		145,926		145,926		145,926		145,926			39
40	Barber and Beauty Shops			5,305	5,305		5,305		5,305			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,056	79,056		79,056		79,056			42
43	Other (specify):* Non-allowable cost			35,955	35,955		35,955	(35,955)				43
44	TOTAL Special Cost Centers		145,926	120,316	266,242		266,242	(35,955)	230,287			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,761,602	648,253	2,392,015	5,801,870		5,801,870	(147,190)	5,654,680			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	(6,386)	30		9
10	Interest and Other Investment Income	(1,274)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,180)	43		13
14	Non-Care Related Interest	(11,500)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,979)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,247)	43		24
25	Fund Raising, Advertising and Promotional	(13,938)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(4,830)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,334)		\$	30

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)	(98,856)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,856)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (147,190)		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		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

The Arbor

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NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	X-Ray Part A	\$ 1,862	43	1
2	Lab Part A	(2,107)	43	2
3	Disallow Franchise Tax	(375)	43	3
4	Disallow Non-Allowable Dues	(691)	20	4
5	Offset Vending Machine Revenue	(3,073)	43	5
6	Disallow Amortization Expense	(446)	32	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	(4,830)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(691)	0	0	0	0	0	0	0	0	0	0	(691)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(691)	0	0	0	0	0	0	0	0	0	0	(691)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(691)	0	0	0	0	0	0	0	0	0	0	(691)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	(6,386)	91,245	0	0	0	0	0	0	0	0	0	84,859	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,220)	280,427	0	0	0	0	0	0	0	0	0	267,207	32
33	Real Estate Taxes	0	54,211	0	0	0	0	0	0	0	0	0	54,211	33
34	Rent-Facility & Grounds	0	(551,880)	0	0	0	0	0	0	0	0	0	(551,880)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	26,766	0	0	0	0	0	0	0	0	0	26,766	36
37	TOTAL Ownership	(19,606)	(99,231)	0	(118,837)	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):*	(28,037)	375	0	0	0	0	0	0	0	0	0	(27,662)	43
44	TOTAL Special Cost Centers	(28,037)	375	0	(27,662)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(48,334)	(98,856)	0	(147,190)	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
John C Florina, Sr.	30			Itasca Shelter	Itasca	Lessor
Duane Jacobson	30			Care, LLC		
Charles Ricci	30					
John C Florina, Jr.	10					

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	30 Depreciation	\$	Itasca Shelter Care, LLC	100.00%	\$ 91,245	\$ 91,245	1
2	V	32 Interest		Itasca Shelter Care, LLC	100.00%	283,971	283,971	2
3	V	32 Interest Income		Itasca Shelter Care, LLC	100.00%	(3,544)	(3,544)	3
4	V	33 Real Estate Taxes		Itasca Shelter Care, LLC	100.00%	54,211	54,211	4
5	V	34 Rental Income	551,880	Itasca Shelter Care, LLC	100.00%		(551,880)	5
6	V	36 MIP Insurance		Itasca Shelter Care, LLC	100.00%	26,766	26,766	6
7	V	43 Franchise Tax		Itasca Shelter Care, LLC	100.00%	250	250	7
8	V	43 Trust Fees		Itasca Shelter Care, LLC	100.00%	125	125	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 551,880			\$ 453,024	\$ * (98,856)	14

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

Facility Name & ID Number

The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	John C Florina, Sr	Owner	Board	30.00	None	5	8.00	Director Fees	\$ 10,000	L18, C3	1
2	Duane Jacobson	Owner	Board	30.00	None	5	8.00	Director Fees	10,000	L18, C3	2
3	Charles Ricci	Owner	Board	30.00	None	5	8.00	Director Fees	10,000	L18, C3	3
4	John C Florina, Jr	Asst Admin/Admin	Administration	10.00	None	40	100.00	Salary	100,367	L17, C1	4
5	Daniel Florina	Contractor	Maintenance	0.00	None	Varied	Varied	Contract	3,528	L6, C3	5
6	Katherine Florina	Admin Assistant	Clerical	0.00	None	6	15.00	Wages	810	L21, C1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 134,705		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

SEE ACCOUNTANTS' COMPILATION REPORT

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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 _____

Street Address N/A

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3	N/A								3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	Cambridge		X	Mortgage	\$28,440.00	3/1/05	\$ 5,089,300	\$ 5,712,185	03/01/40	0.0583	\$ 339,681	1								
2	First Chicago Bank & Trust		X	Line of Credit		5/1/08	175,000	175,000	5/1/09	0.0500	218	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Shareholder Loans	x		Working Capital	None	12/31/03	230,000	230,000	on demand	0.0500	11,500	6								
7												7								
8												8								
9	TOTAL Facility Related				\$28,440.00		\$ 5,494,300	\$ 6,117,185			\$ 351,399	9								
B. Non-Facility Related*																				
10												10								
11											Nonallowable Shareholder Interest	(11,500)	11							
12											Interest Income Offset	(4,818)	12							
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (16,318)	14								
15	TOTALS (line 9+line14)						\$ 5,494,300	\$ 6,117,185			\$ 335,081	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,766 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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 The Arbor COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0019471

CONTACT PERSON REGARDING THIS REPORT John C. Florina, Jr.

TELEPHONE (630) 773-9416 FAX #: (630) 773-9434

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>03-17-102-040</u>	<u>Nursing Home</u>	\$ <u>1,838.42</u>	\$ <u>1,838.42</u>
2. <u>03-17-102-041</u>	<u>Nursing Home</u>	\$ <u>30,235.66</u>	\$ <u>30,235.66</u>
3. <u>03-17-102-045</u>	<u>Nursing Home</u>	\$ <u>30,937.26</u>	\$ <u>30,937.26</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>63,011.34</u>	\$ <u>63,011.34</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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,391 B. General Construction Type: Exterior Brick Frame Block Number of Stories Two

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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Patient Care</u>	<u>41,000</u>	<u>1975</u>	<u>\$ 9,559</u>	<u>1</u>
2	<u>Patient Care</u>	<u>44,336</u>	<u>1992</u>	<u>10,446</u>	<u>2</u>
3	TOTALS	85,336		\$ 20,005	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	68	1975	1975	\$ 271,012	\$	40	\$ 6,775	\$ 6,775	\$ 227,272	4
5		1975	1975	187,817		25			187,817	5
6		1975	1975	113,922		20			113,922	6
7		1975	1975	20,747		10			20,747	7
8	76	1993	1993	2,533,506		40	63,338	63,338	992,468	8
	Improvement Type**									
9	Building Improvements		1976	7,019		25			7,019	9
10	Building Improvements		1976	10,352		40	259	259	8,412	10
11	Building Improvements		1976	2,620		36	73	73	2,153	11
12	Building Improvements		1976	243		10			243	12
13	Building Improvements		1976	608		4			608	13
14	Building Improvements		1987	5,847		20			5,847	14
15	Building Improvements		1988	32,894		35	940	940	18,956	15
16	Building Improvements		1991	32,267		35	922	922	16,135	16
17	Building Improvements		1993	168,024		40	4,201	4,201	65,113	17
18	Building Improvements		1993	21,405		40	549	549	8,313	18
19	Building Improvements		1987	12,923	410	35	410		7,979	19
20	Building Improvements		1988	6,270	199	35	199		3,780	20
21	Building Improvements		1990	21,197	673	35	673		11,274	21
22	Building Improvements		1991	986	31	35	31		494	22
23	Building Improvements		1992	7,503	238	35	238		3,556	23
24	Building Improvements		1993	12,681	325	40	325		4,922	24
25	Building Improvements		1994	3,100	79	40	79		1,129	25
26	Building Improvements		1994	11,175	287	40	287		4,055	26
27	Building Improvements		1995	15,605		10			15,605	27
28	Cabinets		1996	2,768	89	31	89		1,113	28
29	Electrical Fixtures		1996	4,972	160	31	160		1,960	29
30	Cabinets		1996	3,097	100	31	100		1,208	30
31	Building Improvements		1984	12,774		10			12,774	31
32	Building Improvements		1985	7,314		10			7,314	32
33	Building Improvements		1986	4,044		8			4,044	33
34	Building Improvements		1986	1,379		8			1,379	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Front Door Security System	1997	\$ 6,230	\$ 201	31	\$ 201		\$ 2,312	37
38	Concrete Pads for Washers	1997	4,430	143	31	143		1,632	38
39	Carpeting	1997	7,271	235	31	235		2,604	39
40	Complete Communications-Nurse Calling System	1998	4,543	147	31	147		1,507	40
41	New Door Opening	1999	1,798	58	31	58		575	41
42	Window Replacement	2000	4,801	155	31	155		1,253	42
43	Roof	2001	3,665	118	31	118		905	43
44	Hot Water Heater	2001	2,891	93	31	93		705	44
45	Hot Water Heater	2002	885	29	31	29		200	45
46	Landscape Improvements (sidewalks/walkways)	2002	925	30	31	29	(1)	186	46
47	Driveway	2004	2,432	78	31	78		345	47
48	Water Heaters	2005	3,429	111	31	111		425	48
49	Air Conditioners	2005	1,654	53	31	53		177	49
50	Office Rewiring	2006	745	24	31	24		60	50
51	Relocate Bookkeeping Office	2006	8,245	266	31	266		665	51
52	Heat Pump Replacement	2006	500	16	31	16		40	52
53	Air Conditioning Unit	2006	7,150	231	31	231		577	53
54	Drain Line Replacement	2006	900	29	31	29		73	54
55	Dementia Unit - 2 North	2006	424,851	13,705	31	13,705		35,606	55
56	Carpet South Hallway	2007	11,300	365	31	365		547	56
57	Carpet North Hallway	2007	7,200	232	31	232		348	57
58	Carpet Business Office	2007	3,236	104	31	104		156	58
59	New Canopy & Brick Pavers for the Front Entrance	2007	42,810	1,381	31	1,381		2,071	59
60	Replace door, pain & wallpaper S Wing Living Room	2007	5,235	169	31	169		253	60
61	Replace entire nurse call system in north wing	2007	33,240	1,072	31	1,072		1,608	61
62	Oven/range accessories	2008	6,849	342	10	342		342	62
63	Insulated window units	2008	4,882	53	31	79	26	79	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,138,168	\$ 22,031		\$ 99,113	\$ 77,082	\$ 1,812,862	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 544,154	\$ 15,253	\$ 23,405	\$ 8,152	5-10	\$ 490,277	71
72	Current Year Purchases	6,780	859	484	(375)	7 Yrs	484	72
73	Fully Depreciated Assets	178,867					178,867	73
74								74
75	TOTALS	\$ 729,801	\$ 16,112	\$ 23,889	\$ 7,777		\$ 669,628	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	Patient Care	2001 Chevrolet Bus	2001	\$ 46,219	\$	\$	\$	5	\$ 46,219	76
77										77
78										78
79										79
80	TOTALS			\$ 46,219	\$	\$	\$		\$ 46,219	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)	\$ 4,934,193	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,143	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,002	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84,859	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,528,709	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ N/A Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2005 Cadillac CTS	\$ 671.61	\$ 1,343	17
18	Administrative	2008 Chevrolet Suburban	695.00	6,950	18
19					19
20					20
21	TOTAL		\$ #####	\$ 8,293	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

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>It is the policy of this facility to only hire certified nurses aides. 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>
---	---	--

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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	L10A, C3	hrs	\$	1,587	\$ 121,469	\$	1,587	\$ 121,469	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		217	20,091		217	20,091	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,739	131,990		1,739	131,990	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				145,926		145,926	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			\$	3,543	\$ 273,550	\$ 145,926	3,543	\$ 419,476	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor

0019471

Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 6,898	\$ 99,947	1
2	Cash-Patient Deposits	17,211	17,211	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	1,350,950	1,350,950	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,724	73,724	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow</u>		140,435	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,448,783	\$ 1,682,267	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,005	13
14	Buildings, at Historical Cost		3,127,004	14
15	Leasehold Improvements, at Historical Cost	689,459	1,011,164	15
16	Equipment, at Historical Cost	442,295	776,020	16
17	Accumulated Depreciation (book methods)	(468,549)	(2,528,709)	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): <u>Mortgage Costs</u>	1,262	32,909	22
23	Other(specify): <u>Deferred Costs-Apts</u>		1,272	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 664,467	\$ 2,439,665	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,113,250	\$ 4,121,932	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 326,307	\$ 284,454	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,500	16,500	28
29	Short-Term Notes Payable	405,000	405,000	29
30	Accrued Salaries Payable	96,280	96,280	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,354	3,354	31
32	Accrued Real Estate Taxes(Sch.IX-B)		63,000	32
33	Accrued Interest Payable	69,218	93,038	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 21A</u>	208,213	5,573	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,124,872	\$ 967,199	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	675,150	5,712,185	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 675,150	\$ 5,712,185	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,800,022	\$ 6,679,384	46
47	TOTAL EQUITY(page 18, line 24)	\$ 313,228	\$ (2,557,452)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,113,250	\$ 4,121,932	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

The Arbor of Itasca, Inc.
FYE 12/31/08
Medicaid Cost Report Workpapers

Schedule 17A

XV. BALANCE SHEET
C. Current Liabilities

Line 36: Other Current Liabilities (Specify)

	<u>Operating</u>	<u>After Consolidation</u>
RENT RECEIVABLE	-	202,640
NH CURRENT PORTION MORTGAGE	(12,224)	(12,224)
NH RENT PAYABLE	(141,320)	(141,320)
NH DUE TO IDPA-INTEGRITY AUDIT	(25,041)	(25,041)
DUE TO MEDICARE-BAD DEBTS	(29,628)	(29,628)
	<u>(208,213)</u>	<u>(5,573)</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 307,360	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 307,360	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,870	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) Rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 5,868	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)	\$ 313,228	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 5,676,138	1
2	Discounts and Allowances for all Levels	(407,232)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,268,906	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	311,728	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 311,728	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	8,050	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	131,875	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,028	19
20	Radiology and X-Ray		20
21	Other Medical Services	57,054	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 199,007	23
	D. Non-Operating Revenue		
24	Contributions	1,700	24
25	Interest and Other Investment Income***	1,274	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,974	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		21,274	28
28a		3,851	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,125	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,807,740	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,002,224	31
32	Health Care	2,884,938	32
33	General Administration	990,569	33
	B. Capital Expense		
34	Ownership	657,897	34
	C. Ancillary Expense		
35	Special Cost Centers	187,186	35
36	Provider Participation Fee	79,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,801,870	40
41	Income before Income Taxes (line 30 minus line 40)**	5,870	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,870	43

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

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

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

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

Facility Name & ID Number The Arbor

0019471

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,403	2,232	\$ 86,628	\$ 38.81	1
2	Assistant Director of Nursing	852	904	24,243	26.82	2
3	Registered Nurses	16,461	16,541	494,729	29.91	3
4	Licensed Practical Nurses	12,029	12,037	366,515	30.45	4
5	CNAs & Orderlies	76,342	76,542	1,059,208	13.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,181	2,292	38,245	16.69	9
10	Activity Assistants	6,956	6,964	64,393	9.25	10
11	Social Service Workers	2,217	2,080	44,473	21.38	11
12	Dietician					12
13	Food Service Supervisor	2,432	2,072	39,666	19.14	13
14	Head Cook	6,394	6,418	78,119	12.17	14
15	Cook Helpers/Assistants	14,950	14,973	122,061	8.15	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,229	2,072	91,155	43.99	20
21	Assistant Administrator	2,490	2,080	100,367	48.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,985	7,015	138,028	19.68	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: Care Plans	659	645	13,772	21.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,580	154,867	\$ 2,761,602 *	\$ 17.83	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	158	\$ 7,724	L1, C3	35
36	Medical Director	125	11,250	L9, C3	36
37	Medical Records Consultant	26	1,530	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	110	2,597	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,272	L11, C3	44
45	Social Service Consultant	33	2,178	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	476	\$ 26,551		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	291	\$ 15,462	L10, C3	50
51	Licensed Practical Nurses	5,379	210,401	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,670	\$ 225,863		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **The Arbor**

0019471

Report Period Beginning: **01/01/08**

Ending: **12/31/08**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Thomas Annarella	Administrator	0	\$ 91,155	Workers' Compensation Insurance	\$ 56,926	IDPH License Fee	\$	
John C Florina, Jr	Asst Administrator	10	100,367	Unemployment Compensation Insurance	22,221	Advertising: Employee Recruitment	7,923	
				FICA Taxes	212,921	Health Care Worker Background Check (Indicate # of checks performed <u>139</u>)	1,670	
				Employee Health Insurance	68,919	Patient Background Checks		
				Employee Meals		Illinois Health Care Association	7,949	
				Illinois Municipal Retirement Fund (IMRF)*		Chicago Tribune	437	
				Other Employee Benefits	6,895	Itasca Cyclone	300	
						Itasca Business Council	100	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 191,522			See Schedule 21A	12,125	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
N/A			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 367,882	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 30,504	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Achieve Software	Computer Services		\$ 10,133	N/A		\$	Out-of-State Travel	\$
Stratton, Giganti, Stone & Kopec	Legal		21,713					
Ivans	Computer Services		1,066					
Porte Brown LLC	Accounting		5,655				In-State Travel	
Personnel Planners	U/C Consulting		868					
Farnsworth Group	Architecture		813					
McGladrey & Pullen	Accounting		34,571				Seminar Expense	755
Maxim Staff Solutions	Staffing Services		14,800				See Schedule 21A	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 89,619	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 755

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

The Arbor of Itasca, Inc.
Provider # 0019471
01/01/08 to 12/31/08

Schedule 21A

XIX. SUPPORT SCHEDULE

F. Dues, Fees, Subscriptions and Promotions

Balance		18,379
American Medical Directors	198	
Miscellaneous Dues & Subscriptions	475	
Village of Itasca	705	
DuPage County Health Department	850	
Secretary of State	377	
Centers for Mcare & Mcaid Services	9,370	
Miscellaneous Licenses & Fees	<u>150</u>	
	12,125	
Total (agrees to Schedule V line 20, col.8)		<u><u>30,504</u></u>

G. Travel and Seminar

Balance		2,653
Reclass To Acct 8000	(2,398)	
Reclass From Acct 5016	<u>500</u>	
	(1,898)	(1,898)
Total (agrees to Schedule V line 24, col.8)		<u><u>755</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor# 0019471Report Period Beginning: 01/01/08Ending: 12/31/08**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. Illinois Health Care Assoc \$7,949
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 78,628 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,056
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? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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