



Facility Name & ID Number The Arbor

# 0019471 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			2,400	2,400	8
9	SNF/PED					9
10	ICF	24,042	6,937		30,979	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,042	6,937	2,400	33,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.51%

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

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 2,400

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: 12/31/09 Fiscal Year: 12/31/09

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	242,234	33,247	6,864	282,345		282,345		282,345		1
2	Food Purchase		205,037		205,037		205,037		205,037		2
3	Housekeeping		11,388	250,395	261,783		261,783		261,783		3
4	Laundry		106		106		106		106		4
5	Heat and Other Utilities			124,935	124,935		124,935		124,935		5
6	Maintenance		13,882	63,987	77,869		77,869		77,869		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	242,234	263,660	446,181	952,075		952,075		952,075		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	2,017,483	161,218	75,037	2,253,738		2,253,738		2,253,738		10
10a	Therapy			286,671	286,671		286,671		286,671		10a
11	Activities	113,498	4,101	1,280	118,879		118,879		118,879		11
12	Social Services	44,576		2,682	47,258		47,258		47,258		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,175,557	165,319	387,270	2,728,146		2,728,146		2,728,146		16
	<b>C. General Administration</b>										
17	Administrative	196,535			196,535		196,535		196,535		17
18	Directors Fees			22,500	22,500		22,500		22,500		18
19	Professional Services			120,493	120,493		120,493		120,493		19
20	Dues, Fees, Subscriptions & Promotions			16,012	16,012		16,012	(691)	15,321		20
21	Clerical & General Office Expenses	159,153	67,870	23,785	250,808		250,808		250,808		21
22	Employee Benefits & Payroll Taxes			391,009	391,009		391,009		391,009		22
23	Inservice Training & Education			2,331	2,331		2,331		2,331		23
24	Travel and Seminar			3,089	3,089		3,089	(1,676)	1,413		24
25	Other Admin. Staff Transportation							1,676	1,676		25
26	Insurance-Prop.Liab.Malpractice			119,059	119,059		119,059		119,059		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	355,688	67,870	698,278	1,121,836		1,121,836	(691)	1,121,145		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,773,479	496,849	1,531,729	4,802,057		4,802,057	(691)	4,801,366		29

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

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

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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	
	<b>D. Ownership</b>											
30	Depreciation			35,584	35,584		35,584	88,076	123,660			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,042	70,042		70,042	271,167	341,209			32
33	Real Estate Taxes							76,325	76,325			33
34	Rent-Facility & Grounds			440,880	440,880		440,880	(440,880)				34
35	Rent-Equipment & Vehicles							8,340	8,340			35
36	Other (specify):* <b>Mortgage Insurance</b>							26,486	26,486			36
37	<b>TOTAL Ownership</b>			546,506	546,506		546,506	29,514	576,020			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		133,889		133,889		133,889		133,889			39
40	Barber and Beauty Shops			4,422	4,422		4,422		4,422			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,840	78,840		78,840		78,840			42
43	Other (specify):* <b>Non-allowable cost</b>			32,506	32,506		32,506	(34,016)	(1,510)			43
44	<b>TOTAL Special Cost Centers</b>		133,889	115,768	249,657		249,657	(34,016)	215,641			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,773,479	630,738	2,194,003	5,598,220		5,598,220	(5,193)	5,593,027			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,614	30		9
10	Interest and Other Investment Income	(4,094)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,072)	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	(616)	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	(4,322)	43		24
25	Fund Raising, Advertising and Promotional	(14,436)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(229)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(6,388)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (36,043)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	30,850		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 30,850		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (5,193)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44					44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Labs-Part A	\$ (1,903)	43	1
2	Disallow Franchise Tax	(250)	43	2
3	Disallow Non-Allowable Dues	(691)	20	3
4	Offset Vending Machine Revenue	(3,098)	43	4
5	Disallow Amortization Expense	(446)	32	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
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26				26
27				27
28				28
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(6,388)		49

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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	N/A		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		\$ 89,274	\$ 89,274	1
2	V	32 Interest		Itasca Shelter Care, LLC		279,736	279,736	2
3	V	32 Interest Income	341	Itasca Shelter Care, LLC			(341)	3
4	V	33 Real Estate Taxes		Itasca Shelter Care, LLC		76,325	76,325	4
5	V	34 Rental Income	440,880	Itasca Shelter Care, LLC			(440,880)	5
6	V	36 MIP Insurance		Itasca Shelter Care, LLC		26,486	26,486	6
7	V	43 Franchise Tax		Itasca Shelter Care, LLC		250	250	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 441,221			\$ 472,071	\$ * 30,850	14

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

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## 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 Florina, Sr.	Owner	Board	30.00	None	5	8.00	Director Fees	\$ 7,500	L18, C3	1
2	Duane Jacobson	Owner	Board	30.00	None	5	8.00	Director Fees	7,500	L18, C3	2
3	Charles Ricci	Owner	Board	30.00	None	5	8.00	Director Fees	7,500	L18, C3	3
4	John Florina, Jr.	Asst Admin / Admin	Administration	10.00	None	40	100.00	Salary	104,118	L17, C1	4
5	Daniel Florina	Contractor	Maintenance	0.00	None	Varied	Varied	Contract	2,480	L6, C3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 129,098		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

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

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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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Cambridge		X	Mortgage	\$28,440.00	3/1/05	\$ 5,089,300	\$ 5,628,110	3/1/40	0.0583	\$ 341,518	1							
2	First Chicago Bank & Trust		X	Line of Credit		5/1/08	175,000		5/1/09	0.0500	4,126	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
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	\$ 5,858,110			\$ 357,144	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11										Nonallowable Shareholder Interest	(11,500)	11							
12										Interest Income Offset	(4,435)	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (15,935)	14							
15	TOTALS (line 9+line14)						\$ 5,494,300	\$ 5,858,110			\$ 341,209	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,486 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.)

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





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**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	<b>TOTALS</b>	<b>85,336</b>		<b>\$ 20,005</b>	<b>3</b>

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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	\$	\$	\$ 271,012	4
5		1975	1975	187,817		25		1,961,739	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	80,429	40	79,678	(751)	1,368,241	8
<b>Improvement Type**</b>										
9	Building Improvements		1976	7,019		25			7,019	9
10	Building Improvements		1976	10,352		40			8,671	10
11	Building Improvements		1976	2,620		36			2,226	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	1,044	35	940	(104)	20,486	15
16	Building Improvements		1991	32,267	1,024	35	922	(102)	17,200	16
17	Building Improvements		1993	168,024	5,334	40	4,201	(1,133)	73,452	17
18	Building Improvements		1993	21,405	549	39	549		9,108	18
19	Building Improvements		1987	12,923		35	410	410	9,239	19
20	Building Improvements		1988	6,270		35	199	199	4,238	20
21	Building Improvements		1990	21,197		35	672	672	12,835	21
22	Building Improvements		1991	986		35	31	31	572	22
23	Building Improvements		1992	7,503		35	238	238	4,079	23
24	Building Improvements		1993	12,681		40	325	325	5,434	24
25	Building Improvements		1994	3,100		40	79	79	1,235	25
26	Building Improvements		1994	11,175		40	287	287	4,433	26
27	Building Improvements		1995	15,605		10			15,605	27
28	Cabinets		1996	2,768		31	89	89	1,205	28
29	Electrical Fixtures		1996	4,972		31	160	160	2,125	29
30	Cabinets		1996	3,097		31	100	100	1,307	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 &amp; ID Number The Arbor

# 0019471

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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	\$	31	\$ 201	\$ 201	\$ 2,512	37
38	Concrete Pads for Washers	1997	4,430		31	143	143	1,774	38
39	Carpeting	1997	7,271		31	235	235	2,834	39
40	Complete Communications-Nurse Calling System	1998	4,543		31	147	147	1,649	40
41	New Door Opening	1999	1,798		31	58	58	633	41
42	Window Replacement	2000	4,801		31	155	155	1,407	42
43	Roof	2001	3,665		31	118	118	1,025	43
44	Hot Water Heater	2001	2,891		31	93	93	800	44
45	Hot Water Heater	2002	885		31	29	29	226	45
46	Landscape Improvements (sidewalks/walkways)	2002	925		31	30	30	221	46
47	Driveway	2004	2,432		31	78	78	431	47
48	Water Heaters	2005	3,429		31	111	111	535	48
49	Air Conditioners	2005	1,654		31	53	53	231	49
50	Office Rewiring	2006	745		31	24	24	96	50
51	Relocate Bookkeeping Office	2006	8,245		31	266	266	1,064	51
52	Heat Pump Replacement	2006	500		31	16	16	60	52
53	Air Conditioning Unit	2006	7,150		31	231	231	826	53
54	Drain Line Replacement	2006	900		31	29	29	90	54
55	Dementia Unit - 2 North	2006	424,851		31	13,705	13,705	43,399	55
56	Carpet South Hallway	2007	11,300		31	365	365	1,063	56
57	Carpet North Hallway	2007	7,200		31	232	232	677	57
58	Carpet Business Office	2007	3,236		31	104	104	217	58
59	New Canopy & Brick Pavers for the Front Entrance	2007	42,810		31	1,381	1,381	3,683	59
60	Replace door, pain & wallpaper S Wing Living Room	2007	5,235		31	169	169	436	60
61	Replace entire nurse call system in north wing	2007	33,240		31	1,072	1,072	2,145	61
62	Oven/range accessories	2008	6,849		10	685	685	1,027	62
63	Insulated window units	2008	4,882		31	157	157	210	63
64	Smoke Detectors	2009	4,020		10	101	101	101	64
65	Dish Room Improvements	2009	4,110		31	33	33	33	65
66	Renovation of tiles, walls, chair rail, partial nurses station	2009	7,179		31	174	174	174	66
67									67
68	To agree to financial statement depreciation			(54,595)			54,595		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,153,477	\$ 33,785		\$ 109,075	\$ 2,037,029	\$ 2,263,996	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:

01/01/09

Ending:

12/31/09

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	\$ 125,742	\$ 1,799	\$ 14,585	\$ 12,786	5-10 Yrs	\$ 70,596	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	515,613					515,613	73
74								74
75	TOTALS	\$ 641,355	\$ 1,799	\$ 14,585	\$ 12,786		\$ 586,209	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	2		
	Reference	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)	\$ 4,861,056	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,584	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,660	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 88,076	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,896,424	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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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>N/A</u>			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	<u>Administrative</u>	<u>2008 Chevrolet Suburban</u>	\$ <u>695.00</u>	\$ <u>8,340</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>695.00</u>	\$ <u>8,340</u>	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	1,541	\$ 116,406	\$	1,541	\$ 116,406	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		391	34,542		391	34,542	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,748	135,723		1,748	135,723	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				133,889		133,889	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	<b>TOTAL</b>			\$	3,680	\$ 286,671	\$ 133,889	3,680	\$ 420,560	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# 0019471Report Period Beginning: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 8,793	\$ 12,020	1
2	Cash-Patient Deposits	32,278	32,278	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>65,000</u> )	836,898	836,898	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,102	82,102	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow</u>		134,985	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 960,071	\$ 1,098,283	10
<b>B. Long-Term Assets</b>				
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	704,768	1,026,473	15
16	Equipment, at Historical Cost	442,295	687,574	16
17	Accumulated Depreciation (book methods)	(504,133)	(2,896,424)	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 (spe <u>Mortgage Costs</u> )	816	31,262	22
23	Other(specify): <u>Deferred Costs-Apts</u>		1,272	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 643,746	\$ 1,997,166	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,603,817	\$ 3,095,449	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 323,876	\$ 309,432	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,750	12,750	28
29	Short-Term Notes Payable	230,000	230,000	29
30	Accrued Salaries Payable	95,617	95,617	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,259	1,259	31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,000	32
33	Accrued Interest Payable	80,500	104,044	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	247,148	30,228	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 991,150	\$ 855,330	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	652,342	5,628,110	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 652,342	\$ 5,628,110	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,643,492	\$ 6,483,440	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (39,675)	\$ (3,387,991)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,603,817	\$ 3,095,449	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

The Arbor of Itasca, Inc.  
FYE 12/31/09  
Medicaid Cost Report Workpapers

Schedule 17A

XV. BALANCE SHEET  
C. Current Liabilities

Line 36: Other Current Liabilities (Specify)

	Operating	After Consolidation
RENT RECEIVABLE	-	216,920
NH CURRENT PORTION MORTGAGE	(13,222)	(13,222)
NH RENT PAYABLE	(216,920)	(216,920)
DUE TO MEDICARE-BAD DEBTS	(17,006)	(17,006)
	<u>(247,148)</u>	<u>(30,228)</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>313,228</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>313,228</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(352,904)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>1</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(352,903)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(39,675)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number The Arbor

# 0019471

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,076,504	1
2	Discounts and Allowances for all Levels	(340,897)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,735,607</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	321,510	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 321,510</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,211	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	129,467	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,828	19
20	Radiology and X-Ray		20
21	Other Medical Services	37,966	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 175,472</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	649	24
25	Interest and Other Investment Income***	4,094	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 4,743</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Income	4,143	28
28a	Vending Machine Income	3,841	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 7,984</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,245,316</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	952,075	31
32	Health Care	2,728,146	32
33	General Administration	1,121,836	33
<b>B. Capital Expense</b>			
34	Ownership	546,506	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	170,817	35
36	Provider Participation Fee	78,840	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,598,220</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(352,904)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (352,904)</b>	<b>43</b>

\* 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:

**01/01/09**

Ending:

**12/31/09**

**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	2,190	2,080	\$ 78,313	\$ 37.65	1
2	Assistant Director of Nursing	1,930	1,840	55,650	30.24	2
3	Registered Nurses	14,737	14,841	432,080	29.11	3
4	Licensed Practical Nurses	15,315	15,467	460,848	29.80	4
5	CNAs & Orderlies	70,672	70,936	982,923	13.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,179	2,024	37,888	18.72	9
10	Activity Assistants	7,911	7,943	75,610	9.52	10
11	Social Service Workers	2,103	2,016	44,576	22.11	11
12	Dietician					12
13	Food Service Supervisor	2,335	2,048	40,713	19.88	13
14	Head Cook	6,221	6,237	72,224	11.58	14
15	Cook Helpers/Assistants	15,396	15,396	129,297	8.40	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,204	2,064	92,417	44.78	20
21	Assistant Administrator	2,598	2,080	104,118	50.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,061	8,121	159,153	19.60	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 Plan Coordin	269	258	7,669	29.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,121	153,351	\$ 2,773,479 *	\$ 18.09	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	139	\$ 6,864	1(3)	35
36	Medical Director	125	21,600	9(3)	36
37	Medical Records Consultant	17	1,020	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	100	1,099	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,280	11(3)	44
45	Social Service Consultant	39	2,682	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	444	\$ 34,545		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses	1,884	72,918	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,884	\$ 72,918		53

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<u>Thomas Annarella</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 92,417</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 62,142</u>	<u>IDPH License Fee</u>	<u>\$ 995</u>	
<u>John C. Florina, Jr.</u>	<u>Asst Administrator</u>	<u>10</u>	<u>104,118</u>	<u>Unemployment Compensation Insurance</u>	<u>13,220</u>	<u>Advertising: Employee Recruitment</u>	<u>2,276</u>	
				<u>FICA Taxes</u>	<u>215,665</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>95,059</u>	<u>(Indicate # of checks performed <u>102</u>)</u>	<u>1,020</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Healthcare Association</u>	<u>8,139</u>	
				<u>Other Employee Benefits</u>	<u>4,923</u>	<u>Chicago Tribune</u>	<u>176</u>	
						<u>Daily Herald</u>	<u>230</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 196,535</b>			<u>See Schedule 21A</u>	<u>2,485</u>	
<b>(List each licensed administrator separately.)</b>								
<b>B. Administrative - Other</b>				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	
					<b>\$ 391,009</b>			
<b>Description</b>			<b>Amount</b>					
<u>N/A</u>			<u>\$</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>					
<b>(Attach a copy of any management service agreement)</b>								
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Achieve Software</u>	<u>Computer Services</u>		<u>\$ 10,133</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>Stratton, Giganti, Stone &amp; Kopec</u>	<u>Legal</u>		<u>49,834</u>					
<u>Ivans</u>	<u>Computer Services</u>		<u>815</u>					
<u>Porte Brown LLC</u>	<u>Accounting</u>		<u>5,775</u>				<u>In-State Travel</u>	
<u>Personnel Planners</u>	<u>U/C Consulting</u>		<u>1,660</u>					
<u>Farnsworth Group</u>	<u>Architecture</u>		<u>710</u>					
<u>McGladrey &amp; Pullen</u>	<u>Accounting</u>		<u>41,064</u>					
<u>Maxim Staff Solutions</u>	<u>Staffing Services</u>		<u>9,392</u>				<u>Seminar Expense</u>	<u>1,413</u>
<u>Wessels Sherman</u>	<u>Legal</u>		<u>150</u>					
<u>Terrence Zimmer</u>	<u>Legal</u>		<u>235</u>					
<u>Anthony Cocco, Jr.</u>	<u>Web Design</u>		<u>725</u>					
							<u>Entertainment Expense</u>	<u>(</u>
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 120,493</b>	<b>TOTAL</b>		<b>\$</b>	<b>(agree to Sch. V, line 24, col. 8)</b>	<b>\$ 1,413</b>
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

The Arbor of Itasca, Inc.  
Provider # 0019471  
01/01/09 to 12/31/09

Schedule 21A

**XIX. SUPPORT SCHEDULE**

**F. Dues, Fees, Subscriptions and Promotions**

Balance		12,836
American Medical Directors	198	
Miscellaneous Dues & Subscripti	120	
Village of Itasca	545	
DuPage County Health Departme	850	
Secretary of State	402	
Miscellaneous Licenses & Fees	<u>370</u>	
	2,485	
Total (agrees to Schedule V line 20, col.8)		<u>15,321</u>

**G. Travel and Seminar**

Balance		3,089
Reclass To Acct 8000		<u>(1,676)</u>
		<u><u>1,413</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor# 0019471

Report Period Beginning:

01/01/09

Ending:

12/31/09**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 - \$8,139
- (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. \$ 67,789 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. \$ 78,840  
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.
- (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
- (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.

**SEE ACCOUNTANTS' COMPILATION REPORT**