

Facility Name & ID Number Arbour Health Care Center

0034736 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	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	29	Intermediate (ICF)	29	10,585	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	4 Private Pay	Other	Total		
8	SNF	377			377	8	
9	SNF/PED					9	
10	ICF	31,733	726		32,459	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	32,110	726		32,836	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.87%

D. How many bed-hold days during this year were paid by the Department? 1,006 (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)
N/A

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 12/01/1988

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/1988 NO

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

Medicare Intermediary _____

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.

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	166,150	32,922	6,962	206,034		206,034	4,034	210,068		1
2	Food Purchase		161,448		161,448	(33,215)	128,233	(36)	128,197		2
3	Housekeeping	92,180	22,403		114,583		114,583		114,583		3
4	Laundry	80,559	9,148		89,707		89,707		89,707		4
5	Heat and Other Utilities			89,614	89,614		89,614	(855)	88,759		5
6	Maintenance	56,921	27,529	34,574	119,024		119,024	2,282	121,306		6
7	Other (specify):*							829	829		7
8	TOTAL General Services	395,810	253,450	131,150	780,410	(33,215)	747,195	6,254	753,449		8
	B. Health Care and Programs										
9	Medical Director			13,100	13,100		13,100		13,100		9
10	Nursing and Medical Records	1,158,791	21,180	5,655	1,185,626		1,185,626		1,185,626		10
10a	Therapy	16,851			16,851		16,851		16,851		10a
11	Activities	68,139	4,947	2,986	76,072		76,072		76,072		11
12	Social Services	64,673		1,723	66,396		66,396		66,396		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,308,454	26,127	23,464	1,358,045		1,358,045		1,358,045		16
	C. General Administration										
17	Administrative	86,361		223,200	309,561		309,561	(146,987)	162,574		17
18	Directors Fees										18
19	Professional Services			40,452	40,452	(1,560)	38,892	(602)	38,290		19
20	Dues, Fees, Subscriptions & Promotions			19,735	19,735		19,735	(8,079)	11,656		20
21	Clerical & General Office Expenses	55,199	27,308	39,217	121,724		121,724	8,142	129,866		21
22	Employee Benefits & Payroll Taxes			283,041	283,041	33,215	316,256		316,256		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,354	1,354		1,354	225	1,579		24
25	Other Admin. Staff Transportation			1,422	1,422		1,422	1,909	3,331		25
26	Insurance-Prop.Liab.Malpractice			68,485	68,485		68,485	1,179	69,664		26
27	Other (specify):*							25,485	25,485		27
28	TOTAL General Administration	141,560	27,308	676,906	845,774	31,655	877,429	(118,728)	758,701		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,845,824	306,885	831,520	2,984,229	(1,560)	2,982,669	(112,473)	2,870,196		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 Arbour Health Care Center

#0034736

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			19,651	19,651		19,651	92,832	112,483			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,755	2,755		2,755	86,377	89,132			32
33	Real Estate Taxes			99,438	99,438	1,560	100,998	4,290	105,288			33
34	Rent-Facility & Grounds			282,300	282,300		282,300	(282,300)				34
35	Rent-Equipment & Vehicles							7,369	7,369			35
36	Other (specify):*											36
37	TOTAL Ownership			404,144	404,144	1,560	405,704	(91,432)	314,272			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,203	54,203		54,203		54,203			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,845,824	306,885	1,289,867	3,442,576		3,442,576	(203,905)	3,238,671			45

*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

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	(1,944)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,395	30		9
10	Interest and Other Investment Income	(28,291)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				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	(19,512)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,703)	20		28
29	Other-Attach Schedule	(25,369)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,460)		\$	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)	(163,445)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (163,445)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (203,905)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Arbour Health Care Center

ID# 0034736

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalized R&M	\$ (4,843)	06	1
2	Miscellaneous Income	(1,725)	21	2
3	Chicago Nontitle Property Tax	(1,032)	21	3
4	Replacement Income Tax	(6,492)	21	4
5	COPE Dues	(3,376)	20	5
6	Non-Allowable Legal	(1,858)	19	6
7	Building Co. - Illinois Replacement Tax	(2,297)	21	7
8	Building Co. - Amortization	(5,448)	31	8
9	Repairs & Maintenance	1,702	06	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	(25,369)		49

Arbour Health Care Center

ID# 0034736

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arbour Health Care Center# 0034736

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				4,034								4,034	1
2	Food Purchase	(36)											(36)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,944)		1,089									(855)	5
6	Maintenance	(3,141)		1,288	4,135								2,282	6
7	Other (specify):*				829								829	7
8	TOTAL General Services	(5,121)		2,377	8,998								6,254	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(203,773)	56,786								(146,987)	17
18	Directors Fees													18
19	Professional Services	(1,858)		1,025		231							(602)	19
20	Fees, Subscriptions & Promotions	(8,079)											(8,079)	20
21	Clerical & General Office Expenses	(31,058)	2,297	36,903									8,142	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			225									225	24
25	Other Admin. Staff Transportation			1,909									1,909	25
26	Insurance-Prop.Liab.Malpractice			899		280							1,179	26
27	Other (specify):*			21,660	3,825								25,485	27
28	TOTAL General Administration	(40,995)	2,297	(141,152)	60,611	511							(118,728)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,115)	2,297	(138,775)	69,609	511							(112,473)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Arbour Health Care Center# 0034736

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	39,395	51,165			2,273							92,832	30
31	Amortization of Pre-Op. & Org.	(5,448)	5,448											31
32	Interest	(28,291)	111,052			3,616							86,377	32
33	Real Estate Taxes					4,290							4,290	33
34	Rent-Facility & Grounds		(282,300)	11,577		(11,577)							(282,300)	34
35	Rent-Equipment & Vehicles			7,369									7,369	35
36	Other (specify):*													36
37	TOTAL Ownership	5,656	(114,635)	18,946		(1,398)							(91,432)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST													
	(sum of lines 29, 37 & 44)	(40,460)	(112,338)	(119,829)	69,609	(887)							(203,905)	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
See Attached		See Attached		See Attached		
				Arbour Healthcare Center Limited Partnership		Building Co.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Income	\$ 282,300	Arbour Healthcare Center Limited Partnership		\$	(282,300)	1
2	V	32 Mortgage Interest		Arbour Healthcare Center Limited Partnership		111,052	111,052	2
3	V	30 Depreciation		Arbour Healthcare Center Limited Partnership		51,165	51,165	3
4	V	31 Amortization		Arbour Healthcare Center Limited Partnership		5,448	5,448	4
5	V	21 Illinois Replacement Tax		Arbour Healthcare Center Limited Partnership		2,297	2,297	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 282,300			\$ 169,962	\$ * (112,338)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 1,089	\$ 1,089
16	V	6 REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.		1,288	1,288
17	V	17 ADMIN. SAL.-NON OWNER		STAYCARE MANAGEMENT, LTD.		19,427	19,427
18	V	19 PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.		1,025	1,025
19	V	20 DUES, SUBSCRIPTIONS		STAYCARE MANAGEMENT, LTD.			
20	V	21 CLERICAL & GENERAL		STAYCARE MANAGEMENT, LTD.		36,903	36,903
21	V	24 SEMINARS		STAYCARE MANAGEMENT, LTD.		225	225
22	V	25 ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.		1,909	1,909
23	V	26 INSURANCE		STAYCARE MANAGEMENT, LTD.		899	899
24	V	27 EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.		21,660	21,660
25	V	30 DEPRECIATION		STAYCARE MANAGEMENT, LTD.			
26	V	32 INTEREST		STAYCARE MANAGEMENT, LTD.			
27	V	34 BUILDING RENT		STAYCARE MANAGEMENT, LTD.		11,577	11,577
28	V	35 EQUIPMENT RENTAL		STAYCARE MANAGEMENT, LTD.		7,369	7,369
29	V						
30	V	17 MANAGEMENT FEES	223,200	STAYCARE MANAGEMENT, LTD.			(223,200)
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 223,200			\$ 103,371	\$ * (119,829)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 2,017	\$	2,017	15
16	V	1 DIET. COMP - D. WENGROW		STAY CARE MANAGEMENT, LTD.		2,017		2,017	16
17	V	6 MAINT. COMP. - NON-OWNER		STAY CARE MANAGEMENT, LTD.		4,135		4,135	17
18	V	7 EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.		182		182	18
19	V	7 EMP. BEN. - D. WENGROW		STAY CARE MANAGEMENT, LTD.		182		182	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.		465		465	20
21	V	17 ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.		15,000		15,000	21
22	V	17 ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.		41,786		41,786	22
23	V	27 EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.		1,010		1,010	23
24	V	27 EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.		2,815		2,815	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 69,609	\$ *	69,609	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 REPAIRS & MAINTENANCE	\$	DOUBLE YOU REALTY, LLC	100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		231	231	16
17	V	21 OFFICE EXPENSE		DOUBLE YOU REALTY, LLC				17
18	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		280	280	18
19	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		2,273	2,273	19
20	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		3,616	3,616	20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		4,290	4,290	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	11,577	DOUBLE YOU REALTY, LLC			(11,577)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 11,577			\$ 10,690	\$ * (887)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Arbour Health Care Center

#

0034736

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Sara Webster	Relative	Dietary		See Attached	1.00	20.00%	Alloc. Salary	\$ 2,017	01-07	1
2	Jeff Webster	Owner	Administrative	29.12%	See Attached	15.00	21.43%	Alloc. Salary	41,786	17-07	2
3	Howard Wengrow	Owner	Administrative	26.09%	See Attached	5.00	7.69%	Alloc. Salary	15,000	17-07	3
4	Deborah Wengrow	Relative	Dietary		See Attached	1.00	20.00%	Alloc. Salary	2,107	01-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,910		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

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

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									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 Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	209,325	6	\$ 6,940	\$ 32,836	\$ 1,089	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	209,325	6	8,208	32,836	1,288	2
3	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	209,325	6	123,844	123,844	32,836	19,427
4	19	PROFESSIONAL FEES	PATIENT DAYS	209,325	6	6,533	32,836	1,025	4
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	209,325	6		32,836		5
6	21	CLERICAL & GENERAL	PATIENT DAYS	209,325	6	235,254	214,216	32,836	36,903
7	24	SEMINARS	PATIENT DAYS	209,325	6	1,433	32,836	225	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	209,325	6	12,170	32,836	1,909	8
9	26	INSURANCE	PATIENT DAYS	209,325	6	5,734	32,836	899	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	209,325	6	138,077	32,836	21,660	10
11	30	DEPRECIATION	PATIENT DAYS	209,325	6		32,836		11
12	32	INTEREST	PATIENT DAYS	209,325	6		32,836		12
13	34	BUILDING RENT	PATIENT DAYS	209,325	6	73,800	32,836	11,577	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	209,325	6	46,973	32,836	7,369	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 658,966	\$ 338,060	\$ 103,371	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	1	2,017	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	10,104	1	2,017	2
3	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	6	26,360	6	4,135	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	909	1	182	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	909	1	182	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,962	6	465	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	195,000	5	15,000	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	195,000	15	41,786	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	13,128	5	1,010	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	13,138	15	2,815	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					\$ 467,614	\$ 436,568	\$ 69,609	25

SEE ACCOUNTANTS' COMPILATION REPORT

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01/01/09

Ending: 12/31/09

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 DOUBLE YOU REALTY, LLC
 Street Address 3737 W. ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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	6	REPAIRS & MAINTENANCE	PATIENT DAYS	209,325	6	\$	\$ 32,836	\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	209,325	6	1,475	32,836	231	2
3	21	OFFICE EXPENSE	PATIENT DAYS	209,325	6	1	32,836		3
4	26	INSURANCE	PATIENT DAYS	209,325	6	1,785	32,836	280	4
5	30	DEPRECIATION	PATIENT DAYS	209,325	6	14,487	32,836	2,273	5
6	32	INTEREST EXPENSE	PATIENT DAYS	209,325	6	23,050	32,836	3,616	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	209,325	6	27,349	32,836	4,290	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					\$ 68,147	\$	\$ 10,690	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

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									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 Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

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									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 Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

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									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 Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

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									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 Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

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									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 Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

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									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

Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending:

12/31/09

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			
A. Directly Facility Related																			
Long-Term																			
1	MB Financial		X	Mortgage			\$	\$ 3,277,690		\$ 111,052	1								
2	Alloc. From Double You		X							3,616	2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Telephone Equipment		X	Phone System						147	6								
7	MB Financial		X	Line of Credit						2,608	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 3,277,690		\$ 117,423	9								
B. Non-Facility Related*																			
10	Interest Income		X							(28,291)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (28,291)	14								
15	TOTALS (line 9+line14)						\$	\$ 3,277,690		\$ 89,132	15								

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

* 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.)

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related										20									

* 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.)

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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>Facility</u>		<u>1996</u>	<u>\$ 118,000</u>	<u>1</u>
2	<u>Allocated Double You</u>			<u>7,843</u>	<u>2</u>
3	TOTALS			\$ 125,843	3

SEE ACCOUNTANTS' COMPILATION REPORT

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1989	7,848		20	164	164	7,789	9
10	Various		1990	41,826		20	1,481	1,481	40,831	10
11	Various		1992	21,600		20	1,080	1,080	18,540	11
12	Various		1993	5,318		20	266	266	4,481	12
13	Various		1995	21,420		20	1,070	1,070	15,562	13
14	Various		1996	16,100		20	805	805	10,868	14
15	Various		1997	53,433		20	2,672	2,672	32,968	15
16	Various		1998	15,100		20	755	755	8,586	16
17	Various		2000	11,154		20	558	558	5,334	17
18	Various		2001	18,601		20	931	931	8,118	18
19	Various		2002	14,426		20	823	823	6,254	19
20	Various		2003	968		20	48	48	331	20
21	Various		2004	34,368		20	3,311	3,311	18,495	21
22	Various		2005	46,614		20	3,864	3,864	20,115	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	1,995,443	51,165		66,515	15,350	1,314,944	67
68	Related Party Allocations (Pages 12H & 12I)	78,444	1,922		2,095	173	14,342	68
69	Financial Statement Depreciation		7,693			(7,693)		69
70	TOTAL (lines 4 thru 69)	\$ 2,382,663	\$ 60,780		\$ 86,438	\$ 25,658	\$ 1,527,558	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,382,663	\$ 60,780		\$ 86,438	\$ 25,658	\$ 1,527,558	1
2	Cable/Satellite	2006	7,600		20	760	760	2,343	2
3	Nursing Station Cabinets	2007	8,850		20	1,770	1,770	3,983	3
4	Fire Alarm System	2007	4,500		20	300	300	750	4
5	Nursing Station Improvement - Cabinets	2008	8,850		20	885	885	1,623	5
6	Nursing Station Improvement - Modifications	2008	1,500		20	150	150	288	6
7	Shower Room And First Floor Day Room Improvement - Flooring	2008	49,438		20	4,944	4,944	7,828	7
8	Custom Built Cabinets	2009	6,800		20	623	623	623	8
9	Removal And Installation Of Floor	2009	16,425		20	958	958	958	9
10	Structural Steel Fireproofing	2009	4,180		20	35	35	35	10
11	Stain And Install 3 Doors	2009	4,405		20	37	37	37	11
12	Air Conditioning	2009	4,843		20	242	242	242	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	TOTAL (lines 1 thru 33)		\$ 2,500,054	\$ 60,780		\$ 97,142	\$ 36,362	\$ 1,546,268	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arbour Health Care Center

0034736

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,500,054	\$ 60,780		\$ 97,142	\$ 36,362	\$ 1,546,268	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,500,054	\$ 60,780		\$ 97,142	\$ 36,362	\$ 1,546,268	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,500,054	\$ 60,780		\$ 97,142	\$ 36,362	\$ 1,546,268	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,500,054	\$ 60,780		\$ 97,142	\$ 36,362	\$ 1,546,268	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arbour Health Care Center

0034736

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	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 2,500,054	\$ 60,780		\$ 97,142	\$ 36,362	\$ 1,546,268
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 2,500,054	\$ 60,780		\$ 97,142	\$ 36,362	\$ 1,546,268

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arbour Health Care Center

0034736

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Arbour Healthcare Center Limited Partnership	1974	1,995,443	51,165	30	66,515	15,350	1,314,944	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 1,995,443	\$ 51,165		\$ 66,515	\$ 15,350	\$ 1,314,944	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You	2003	74,971	1,922		1,922		13,377	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare	2003	3,473		20	173	173	965	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arbour Health Care Center

0034736

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 78,444	\$ 1,922		\$ 2,095	\$ 173	\$ 14,342	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arbour Health Care Center

0034736

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	\$ 105,870	\$ 350	\$ 13,022	\$ 12,672	10	\$ 78,277	71
72	Current Year Purchases	11,283	11,958	1,880	(10,078)	10	1,880	72
73	Fully Depreciated Assets	44,399				10	44,399	73
74								74
75	TOTALS	\$ 161,552	\$ 12,308	\$ 14,902	\$ 2,594		\$ 124,556	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		Allocated from Staycare	2003	\$ 4,392	\$	\$ 439	\$ 439	5	\$ 4,392	76
77										77
78										78
79										79
80	TOTALS			\$ 4,392	\$	\$ 439	\$ 439		\$ 4,392	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)	\$ 2,791,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,088	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 112,483	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,395	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,675,216	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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:				\$			3
4	Additions							4
5	<u>Allocated from Staycare</u>				<u>11,577</u>			5
6								6
7	TOTAL				\$ <u>11,577</u>			7

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

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

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ 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>Allocated from Staycare</u>		\$	\$ <u>7,369</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>7,369</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. _____ /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>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		Contract	Total
		1	2		
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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	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 Arbour Health Care Center

0034736

Report Period Beginning: 01/01/09

Ending: 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 498,130	\$ 498,130	1
2	Cash-Patient Deposits	67,836	67,836	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	778,767	778,767	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,765	68,765	6
7	Other Prepaid Expenses	871	871	7
8	Accounts Receivable (owners or related parties)	5,746	5,746	8
9	Other(specify): <u>See Attached Schedule</u>	1,014	1,014	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,421,129	\$ 1,421,129	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		118,650	13
14	Buildings, at Historical Cost		1,995,443	14
15	Leasehold Improvements, at Historical Cost	299,138	299,138	15
16	Equipment, at Historical Cost	150,978	452,959	16
17	Accumulated Depreciation (book methods)	(221,455)	(1,163,907)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 228,661	\$ 1,702,283	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,649,790	\$ 3,123,412	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 102,526	\$ 102,527	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,835	67,835	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,234	59,234	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,873	21,873	31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,384	101,384	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	24,761	24,761	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 377,613	\$ 377,614	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,277,690	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,277,690	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 377,613	\$ 3,655,304	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,272,177	\$ (531,892)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,649,790	\$ 3,123,412	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,225,682	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,225,682	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	442,495	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	(396,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 46,495	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,272,177	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arbour Health Care Center# 0034736Report Period Beginning: 01/01/09Ending: 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,849,377	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,849,377	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	978	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 978	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	28,291	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,291	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	6,425	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,425	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,885,071	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	780,410	31
32	Health Care	1,358,045	32
33	General Administration	845,774	33
B. Capital Expense			
34	Ownership	404,144	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,442,576	40
41	Income before Income Taxes (line 30 minus line 40)**	442,495	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 442,495	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 Arbour Health Care Center

0034736

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	1,608	1,776	\$ 76,676	\$ 43.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,850	7,451	205,889	27.63	3
4	Licensed Practical Nurses	17,059	18,654	422,997	22.68	4
5	CNAs & Orderlies	32,590	35,029	336,704	9.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,757	1,893	16,851	8.90	8
9	Activity Director	1,944	2,088	27,700	13.27	9
10	Activity Assistants	4,092	4,366	40,439	9.26	10
11	Social Service Workers	3,608	3,912	64,673	16.53	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,120	37,443	17.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,805	13,775	128,707	9.34	15
16	Dishwashers					16
17	Maintenance Workers	4,913	5,438	56,921	10.47	17
18	Housekeepers	7,690	8,520	92,180	10.82	18
19	Laundry	7,168	7,876	80,559	10.23	19
20	Administrator	1,976	2,120	86,361	40.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,573	4,775	55,199	11.56	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	366	470	7,110	15.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,456	3,802	109,415	28.78	33
34	TOTAL (lines 1 - 33)	114,479	124,065	\$ 1,845,824 *	\$ 14.88	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	Monthly	\$ 6,962	01-03	35
36	Medical Director	Monthly	13,100	09-03	36
37	Medical Records Consultant	Monthly	4,688	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	967	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	63	2,986	11-03	44
45	Social Service Consultant	32	1,723	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	95	\$ 30,426		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
<u>Debra L. Patty</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 86,361</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 40,745</u>	<u>IDPH License Fee</u>	<u>\$</u>	<u>Advertising: Employee Recruitment</u>	<u>419</u>	
				<u>Unemployment Compensation Insurance</u>	<u>12,689</u>	<u>Health Care Worker Background Check</u>		<u>(Indicate # of checks performed <u>110</u>)</u>	<u>1,100</u>	
				<u>FICA Taxes</u>	<u>137,788</u>	<u>Patient Background Checks</u>		<u>Dues & Subscriptions</u>	<u>6,168</u>	
				<u>Employee Health Insurance</u>	<u>68,106</u>	<u>Chicago Head Tax</u>		<u>Yellow Pages</u>	<u>4,703</u>	
				<u>Employee Meals</u>	<u>33,215</u>	<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>License/Permits & Fees</u>	<u>3,969</u>	
				<u>401k - Employer</u>	<u>3,385</u>	<u>Union Pension Expense</u>		<u>Less: Public Relations Expense</u>	<u>()</u>	
				<u>Holiday Expense</u>	<u>2,142</u>	<u>Holiday Expense</u>		<u>Non-allowable advertising</u>	<u>()</u>	
								<u>Yellow page advertising</u>	<u>(4,703)</u>	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			<u>\$ 86,361</u>	TOTAL (agree to Schedule V, line 22, col.8)		<u>\$ 316,256</u>	TOTAL (agree to Sch. V, line 20, col. 8)			<u>\$ 11,656</u>
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description				Description	Line #	Amount	Description	Amount		
<u>Management Fees - Stay Care</u>			<u>\$ 223,200</u>				<u>Out-of-State Travel</u>	<u>\$</u>		
							<u>In-State Travel</u>			
							<u>Seminar Expense</u>		<u>1,354</u>	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			<u>\$ 223,200</u>	TOTAL		<u>\$</u>	<u>Allocated from Staycare</u>		<u>225</u>	
C. Professional Services			Amount							
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount		
<u>See Attached</u>	<u>Legal</u>		<u>8,741</u>				<u>Entertainment Expense</u>	<u>()</u>		
<u>FR&R</u>	<u>Accounting</u>		<u>14,587</u>				TOTAL (agree to Sch. V, line 24, col. 8)			<u>\$ 1,579</u>
<u>Personnel Planners</u>	<u>Unemployment Consultant</u>		<u>897</u>							
<u>KBC Computer Services</u>	<u>Computer Expense</u>		<u>3,636</u>							
<u>MDI Technologies</u>	<u>Computer Expense</u>		<u>4,563</u>							
<u>Skidelsky & Associates</u>	<u>Legal-Real Estate Tax Appeal</u>		<u>1,560</u>							
<u>Elderlife Development, LTD</u>	<u>Architectural Consultant</u>		<u>6,468</u>							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			<u>\$ 40,452</u>							

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
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 Arbour Health Care Center# 0034736

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. ICLTC \$ 8,316 IAHC \$1,188
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,396 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. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ 33,215 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? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.