

Facility Name & ID Number Arbour Health Care Center

0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	10,259		865	11,124	8
9	SNF/PED					9
10	ICF	22,354			22,354	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,613		865	33,478	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.65%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/1988

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 70 and days of care provided 865

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	230,356	28,716	6,689	265,761		265,761	8,005	273,766		1
2	Food Purchase		185,120		185,120	(37,559)	147,562		147,562		2
3	Housekeeping	123,739	34,001		157,740		157,740		157,740		3
4	Laundry	79,329	6,826		86,155		86,155		86,155		4
5	Heat and Other Utilities			130,794	130,794		130,794	(4,505)	126,289		5
6	Maintenance	103,670	21,474	87,816	212,960		212,960	(12,813)	200,147		6
7	Other (specify):*							1,162	1,162		7
8	TOTAL General Services	537,094	276,137	225,299	1,038,530	(37,559)	1,000,972	(8,151)	992,821		8
	B. Health Care and Programs										
9	Medical Director			23,400	23,400		23,400		23,400		9
10	Nursing and Medical Records	1,423,467	41,746	9,061	1,474,274		1,474,274		1,474,274		10
10a	Therapy	25,923		1,418	27,341		27,341		27,341		10a
11	Activities	79,575	4,209	528	84,312		84,312		84,312		11
12	Social Services	83,222		264	83,486		83,486		83,486		12
13	CNA Training										13
14	Program Transportation			104	104		104		104		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,612,187	45,955	34,775	1,692,917		1,692,917		1,692,917		16
	C. General Administration										
17	Administrative	97,727		314,359	412,086		412,086	(232,964)	179,122		17
18	Directors Fees										18
19	Professional Services			121,122	121,122	(8,904)	112,218	(31,960)	80,258		19
20	Dues, Fees, Subscriptions & Promotions			28,839	28,839		28,839	(6,580)	22,259		20
21	Clerical & General Office Expenses	85,277	26,945	37,543	149,765		149,765	82,746	232,511		21
22	Employee Benefits & Payroll Taxes			340,673	340,673	37,559	378,232		378,232		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,443	1,443		1,443	236	1,679		24
25	Other Admin. Staff Transportation			2,836	2,836		2,836	2,160	4,996		25
26	Insurance-Prop.Liab.Malpractice			220,218	220,218		220,218	2,294	222,512		26
27	Other (specify):*							41,371	41,371		27
28	TOTAL General Administration	183,004	26,945	1,067,033	1,276,982	28,655	1,305,637	(142,697)	1,162,939		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,332,285	349,037	1,327,107	4,008,429	(8,904)	3,999,525	(150,848)	3,848,677		29

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

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

Facility Name & ID Number Arbour Health Care Center

#0034736

Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,350	15,350		15,350	109,405	124,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							93,335	93,335			32
33	Real Estate Taxes			128,098	128,098	8,904	137,002	1,799	138,801			33
34	Rent-Facility & Grounds			282,300	282,300		282,300	(282,300)				34
35	Rent-Equipment & Vehicles							6,047	6,047			35
36	Other (specify):*											36
37	TOTAL Ownership			425,748	425,748	8,904	434,652	(71,714)	362,938			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,472	125,425	140,897		140,897		140,897			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			251,565	251,565		251,565		251,565			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		15,472	376,990	392,462		392,462		392,462			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,332,285	364,509	2,129,845	4,826,639		4,826,639	(222,562)	4,604,077			45

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

Facility Name & ID Number Arbour Health Care Center

0034736

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,697)	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	58,239	30		9
10	Interest and Other Investment Income	(17,455)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(13,307)	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	(1,234)	20		28
29	Other-Attach Schedule	(45,562)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,016)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		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)	(197,546)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (197,546)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (222,562)		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

Arbour Health Care Center

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Report Period Beginning: 01/01/18

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Capitalized R&M (tax items)	\$ (13,627)	06	1
2	Sequestration	(7,497)	21	2
3	Building Company - Accounting Fees	(1,500)	19	3
4	Building Company - Amortization	(875)	36	4
5	Building Company - Illinois Replacement Tax	(4,163)	21	5
6	Non-Allowable Legal Expense	(3,141)	19	6
7	Non-Care Depreciation (page 13)	(3,580)	30	7
8	PAC Dues	(5,346)	20	8
9	Capitalized R&M	(4,572)	06	9
10	Misc. Income	(1,261)	21	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	(45,562)		49

Arbour Health Care Center

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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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arbour Health Care Center# 0034736

Report Period Beginning:

01/01/18

Ending:

12/31/18

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				8,005								8,005	1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,697)		1,192									(4,505)	5
6	Maintenance	(18,199)		1,323	4,063								(12,813)	6
7	Other (specify):*				1,162								1,162	7
8	TOTAL General Services	(23,896)		2,515	13,230								(8,151)	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			(289,882)	56,918								(232,964)	17
18	Directors Fees													18
19	Professional Services	(4,641)	1,500	(29,072)		253							(31,960)	19
20	Fees, Subscriptions & Promotions	(6,580)											(6,580)	20
21	Clerical & General Office Expenses	(26,228)	4,163	104,811									82,746	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			236									236	24
25	Other Admin. Staff Transportation			2,160									2,160	25
26	Insurance-Prop.Liab.Malpractice			1,866		428							2,294	26
27	Other (specify):*			37,761	3,610								41,371	27
28	TOTAL General Administration	(37,449)	5,663	(172,120)	60,528	681							(142,697)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(61,345)	5,663	(169,605)	73,758	681							(150,848)	29

STATE OF ILLINOIS

Facility Name & ID Number Arbour Health Care Center# 0034736

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	54,659	54,746										109,405	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,455)	109,676			1,114							93,335	32
33	Real Estate Taxes					1,799							1,799	33
34	Rent-Facility & Grounds		(282,300)	14,377		(14,377)							(282,300)	34
35	Rent-Equipment & Vehicles			6,047									6,047	35
36	Other (specify):*	(875)	875											36
37	TOTAL Ownership	36,329	(117,003)	20,424		(11,464)							(71,714)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(25,016)	(111,340)	(149,181)	73,758	(10,783)							(222,562)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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	\$ 282,300	Arbour Health Care Real Estate LLC		\$	\$ (282,300)	1
2	V	19 Accounting Fees		Arbour Health Care Real Estate LLC		1,500	1,500	2
3	V	32 Mortgage Interest		Arbour Health Care Real Estate LLC		109,676	109,676	3
4	V	30 Depreciation		Arbour Health Care Real Estate LLC		54,746	54,746	4
5	V	36 Amortization		Arbour Health Care Real Estate LLC		875	875	5
6	V	21 Illinois Replacement Tax		Arbour Health Care Real Estate LLC		4,163	4,163	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			\$ 170,960	\$ * (111,340)	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.		\$ 1,192	\$ 1,192
16	V	6 REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.		1,323	1,323
17	V	17 ADMIN. SALARY		STAYCARE MANAGEMENT, LTD.		24,477	24,477
18	V	19 PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.		3,673	3,673
19	V	21 CLERICAL & GENERAL - SALARIES		STAYCARE MANAGEMENT, LTD.		108,184	108,184
20	V	21 CLERICAL & GENERAL - OTHER		STAYCARE MANAGEMENT, LTD.		7,832	7,832
21	V	24 SEMINARS		STAYCARE MANAGEMENT, LTD.		236	236
22	V	25 ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.		2,160	2,160
23	V	26 INSURANCE		STAYCARE MANAGEMENT, LTD.		1,866	1,866
24	V	27 EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.		37,761	37,761
25	V	30 DEPRECIATION		STAYCARE MANAGEMENT, LTD.			
26	V	34 BUILDING RENT		STAYCARE MANAGEMENT, LTD.		14,377	14,377
27	V	35 EQUIP. RENTAL-AUTO		STAYCARE MANAGEMENT, LTD.		6,047	6,047
28	V						
29	V						
30	V	17 MANAGEMENT FEE	314,359	STAYCARE MANAGEMENT, LTD.			(314,359)
31	V	19 ADMINISTRATIVE CONSULT.	16,320	STAYCARE MANAGEMENT, LTD.			(16,320)
32	V	21 ADMISSIONS DIRECTOR	11,205	STAYCARE MANAGEMENT, LTD.			(11,205)
33	V	19 REIMBURSEMENT CONSULT.	16,425	STAYCARE MANAGEMENT, LTD.			(16,425)
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 358,309			\$ 209,128	\$ * (149,181)

* 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:

01/01/18

Ending:

12/31/18

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		DIETARY COMP - S. WEBSTER		\$ 2,017	\$	2,017	15
16	V	1		DIETARY COMP - D. WENGROW		5,988		5,988	16
17	V	6		MAINTENANCE COMP.		4,063		4,063	17
18	V	7		EMP. BEN. - S. WEBSTER		202		202	18
19	V	7		EMP. BEN. - D. WENGROW		523		523	19
20	V	7		EMP. BEN. - MAINT. NON-OWNER		437		437	20
21	V	17		ADMIN. COMP - H. WENGROW		14,206		14,206	21
22	V	17		ADMIN. COMP - J. WEBSTER		42,712		42,712	22
23	V	27		EMP. BEN. - H. WENGROW		940		940	23
24	V	27		EMP. BEN. - J. WEBSTER		2,670		2,670	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		\$			\$ 73,758	\$ *	73,758	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	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		253	\$	253	15
16	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		428		428	16
17	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC					17
18	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		1,114		1,114	18
19	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		1,799		1,799	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	34 RENT	14,377	DOUBLE YOU REALTY, LLC				(14,377)	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		\$ 14,377			\$ 3,594	\$ *	(10,783)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		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.

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning: 01/01/18

Ending: 12/31/18

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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:

01/01/18

Ending:

12/31/18

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	Jeffrey Webster	Owner	Administrative	31.65%	See Attached	15	21.43%	Alloc. Salary	\$ 42,712	17-7	1
2	Howard Wengrow	Owner	Administrative	28.62%	See Attached	5	7.69%	Alloc. Salary	14,206	17-7	2
3	Sara Webster	Relative	Dietary	0	See Attached	1	19.96%	Alloc. Salary	2,017	1-7	3
4	Deborah Wengrow	Relative	Dietary	0	See Attached	1	19.96%	Alloc. Salary	5,988	1-7	4
5	Ephraim Braunstein	Relative	Clerical	0	See Attached	6.13	15.33%	Alloc. Salary	15,450	21-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 80,373		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Arbour Health Care Center

0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	218,426	6	\$ 7,776	\$ 33,478	\$ 1,192	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	218,426	6	8,630	33,478	1,323	2
3	17	ADMIN. SALARY	PATIENT DAYS	218,426	6	159,698	159,698	24,477	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	218,426	6	23,962	33,478	3,673	4
5	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	218,426	6	705,841	705,841	108,184	5
6	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	218,426	6	51,101	33,478	7,832	6
7	24	SEMINARS	PATIENT DAYS	218,426	6	1,541	33,478	236	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	218,426	6	14,095	33,478	2,160	8
9	26	INSURANCE	PATIENT DAYS	218,426	6	12,177	33,478	1,866	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	218,426	6	246,373	33,478	37,761	10
11	30	DEPRECIATION	PATIENT DAYS	218,426	6		33,478		11
12	34	BUILDING RENT	PATIENT DAYS	218,426	6	93,800	33,478	14,377	12
13	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	218,426	6	39,457	33,478	6,047	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					\$ 1,364,451	\$ 865,539	\$ 209,128	25

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	1	2,017	1
2	1	DIETARY COMP - D. WENGRO	AVG. HOURS WORKED	5	4	30,000	30,000	1	5,988	2
3	6	MAINTENANCE COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	6	4,063	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,013		1	202	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,618		1	523	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,848		6	437	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	184,684	184,684	5	14,206	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	199,324	199,324	15	42,712	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,223		5	940	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,458		15	2,670	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					\$ 481,782	\$ 450,622		\$ 73,758	25

Facility Name & ID Number Arbour Health Care Center

0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	19	PROFESSIONAL FEES	PATIENT DAYS	218,426	6	1,650	33,478	253	1
2	26	INSURANCE	PATIENT DAYS	218,426	6	2,791	33,478	428	2
3	30	DEPRECIATION	PATIENT DAYS	218,426	6		33,478		3
4	32	INTEREST EXPENSE	PATIENT DAYS	218,426	6	7,271	33,478	1,114	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	218,426	6	11,737	33,478	1,799	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				\$ 23,449	\$		\$ 3,594	25

Facility Name & ID Number Arbour Health Care Center

0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Arbour Health Care Center

0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Arbour Health Care Center

0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Facility Name & ID Number Arbour Health Care Center

0034736 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number

Arbour Health Care Center

0034736

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	MB Financial		X	Mortgage			\$	\$ 2,229,403		\$ 109,676	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 2,229,403		\$ 109,676	9									
B. Non-Facility Related*																				
10	Interest Income		X							(17,455)	10									
11	Allocated from Double You Realty									1,114	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (16,341)	14									
15	TOTALS (line 9+line14)						\$	\$ 2,229,403		\$ 93,335	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.)

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arbour Health Care Center COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0034736
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>11-29-306-024-0000</u>	<u>Long Term Care Property</u>	\$ <u>119,530.06</u>	\$ <u>119,530.06</u>
2.	<u>10-35-329-014-0000</u>	<u>Allocated from Double You Realty</u>	\$ <u>24,601.06</u>	\$ <u>3,770.59</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>144,131.12</u></u>	\$ <u><u>123,300.65</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arbour Health Care Center COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0034736
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning:

01/01/18 Ending:

12/31/18

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).

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: _____ 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1996</u>	<u>\$ 118,000</u>	<u>1</u>
2	<u>Allocated from Double You Realty LLC</u>			<u>7,663</u>	<u>2</u>
3	TOTALS			\$ 125,663	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	99		1996	1974	\$ 1,995,443	\$ 54,746	30	\$ 66,515	\$ 11,769	\$ 1,898,229	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1989		7,848		20			7,789	9
10	Various		1990		7,291		20			7,286	10
11	Various		1992		21,600		20			21,600	11
12	Various		1993		5,318		20			5,225	12
13	Various		1995		21,420		20			21,301	13
14	Various		1996		16,100		20			16,100	14
15	Various		1997		53,433		20			53,429	15
16	Various		1998		15,100		20	471	471	15,097	16
17	Various		2000		11,154		20	558	558	10,354	17
18	Various		2001		18,601		20	930	930	16,489	18
19	Various		2002		14,426		20	620	620	12,306	19
20	Various		2003		968		20	48	48	766	20
21	Various		2004		34,368		20	127	127	33,694	21
22	Various		2005		46,614		20	686	686	42,441	22
23	Various		2006		7,600		20			7,600	23
24	Various		2007		13,350		20	300	300	12,300	24
25	Various		2008		59,788		20	2,220	2,220	59,788	25
26	Various		2009		36,653		20	3,665	3,665	34,883	26
27	Various		2010		35,088		20	2,800	2,800	31,145	27
28	Various		2011		17,160		20	1,696	1,696	14,294	28
29	Various		2012		27,850		20	714	714	4,731	29
30	Various		2013		81,750		20	13,923	13,923	75,883	30
31	Various		2014		13,250		20	663	663	3,179	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
		\$	\$		\$	\$	\$	
67								67
68								68
69								69
70								70
		\$	\$		\$	\$	\$	
		2,642,803	66,516		98,183	31,667	2,439,056	

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 2,642,803	\$ 66,516		\$ 98,183	\$ 31,667	\$ 2,439,056	1
2	Walk In Cooler Repair	2015	2,983		20	149	149	497	2
3	New Water Heater And Installation	2016	10,410		20	868	868	2,241	3
4	New Sidewalk And Concrete Staircase	2016	23,025		20	2,303	2,303	5,756	4
5	Elevator Telephone	2016	2,500		20	71	71	202	5
6	Removal Of Cast Iron, Insulated Piping	2016	3,800		20	109	109	317	6
7	Rental Fee Of Modular Ramp, Installation Fee	2016	2,924		20	84	84	216	7
8	Sewer Work	2016	3,500		20	100	100	233	8
9	Walk In Freezer Repair	2016	2,844		20	81	81	176	9
10	Installation Of Additional Devices To Fire Alarm System	2016	3,400		20	97	97	267	10
11	Elevator Shunt Breaker Installation	2016	6,150		20	308	308	846	11
12	Replace Iron Trap For Drain	2016	2,600		20	130	130	390	12
13	State Water Heater	2017	10,660		20	533	533	844	13
14	Brickwork Around Facility	2017	164,550		20	8,228	8,228	13,027	14
15	Gravel Stop Over Existing Roof	2017	16,150		20	808	808	1,279	15
16	Material Fabrication/Paint/Install Handrails-Landing/Balcony	2017	3,956		20	198	198	330	16
17	Dry System And Sprinklers Under Exterior Canopy	2018	6,125		20	102	102	102	17
18	Repair Of Door Holder System	2018	4,589		20	57	57	57	18
19	Repairs To Heating Boilers And 3Rd Floor Boiler Pump	2018	2,913		20	12	12	12	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)		\$ 2,915,881	\$ 66,516		\$ 112,419	\$ 45,903	\$ 2,465,848	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		\$ 2,915,881	\$ 66,516		\$ 112,419	\$ 45,903	\$ 2,465,848	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)		\$ 2,915,881	\$ 66,516		\$ 112,419	\$ 45,903	\$ 2,465,848	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12C, Carried Forward		\$ 2,915,881	\$ 66,516		\$ 112,419	\$ 45,903	\$ 2,465,848	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)		\$ 2,915,881	\$ 66,516		\$ 112,419	\$ 45,903	\$ 2,465,848	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12D, Carried Forward		\$ 2,915,881	\$ 66,516		\$ 112,419	\$ 45,903	\$ 2,465,848	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)		\$ 2,915,881	\$ 66,516		\$ 112,419	\$ 45,903	\$ 2,465,848	34

**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:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$	\$		\$	\$	\$	1
2									2
3									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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12F, Carried Forward		\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You Realty LLC	2003	73,252		35	1,878	1,878	29,976	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2016	3,985		20	199	199	531	9
10	Allocated from Staycare Management	2003	3,393		20	170	170	2,640	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)		\$ 80,631	\$		\$ 2,247	\$ 2,247	\$ 33,147	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12H, Carried Forward		\$ 80,631	\$		\$ 2,247	\$ 2,247	\$ 33,147	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)		\$ 80,631	\$		\$ 2,247	\$ 2,247	\$ 33,147	34

**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:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 115,676	\$	\$ 11,247	\$ 11,247	10	\$ 92,648	71
72	Current Year Purchases	4,572		457	457	10	457	72
73	Fully Depreciated Assets	382,166				10	382,166	73
74								74
75	TOTALS	\$ 502,414	\$	\$ 11,704	\$ 11,704		\$ 475,271	75

D. Vehicle Costs. (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		Alloc from Staycare Mgmt	2012	\$ 5,187	\$	\$ 632	\$ 632	5	\$ 4,634	76
77										77
78										78
79										79
80	TOTALS			\$ 5,187	\$	\$ 632	\$ 632		\$ 4,634	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)	\$ 3,549,145	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,516	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,755	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 58,239	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,945,753	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	Sec 754 - Land - 2014	\$ 8,259	\$	\$	86
87	Sec 754 - Building - 2014	139,657	3,580	17,760	87
88					88
89					89
90					90
91	TOTALS	\$ 147,916	\$ 3,580	\$ 17,760	91

G. Construction-in-Progress

	Description	Cost	
92	Deposit on Elevator	\$ 15,500	92
93	Modernization		93
94			94
95		\$ 15,500	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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	<u> </u> /2019	\$ <u> </u>
13.	<u> </u> /2020	\$ <u> </u>
14.	<u> </u> /2021	\$ <u> </u>

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 Management</u>		\$ <u> </u>	\$ <u>6,047</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u> </u>	\$ <u>6,047</u>	21

* 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.

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 54,468	\$		\$ 54,468	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,522			13,522	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			54,810			54,810	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				15,429		15,429	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					2,625	43		2,668	13
14	TOTAL			\$		\$ 125,425	\$ 15,472		\$ 140,897	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Arbour Health Care Center

0034736

Report Period Beginning: 01/01/18

Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(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	\$ 481,354	\$ 483,045	1
2	Cash-Patient Deposits	86,298	86,298	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	723,011	723,011	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	221,347	221,347	6
7	Other Prepaid Expenses	1,167	1,167	7
8	Accounts Receivable (owners or related parties)	55,380	55,380	8
9	Other(specify): <u>See Attached Schedule</u>	1,225	1,225	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,569,782	\$ 1,571,473	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		126,259	13
14	Buildings, at Historical Cost		2,135,100	14
15	Leasehold Improvements, at Historical Cost	692,428	692,428	15
16	Equipment, at Historical Cost	237,563	485,063	16
17	Accumulated Depreciation (book methods)	(597,888)	(2,012,233)	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>	792,013	15,500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,124,116	\$ 1,442,117	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,693,898	\$ 3,013,590	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 267,472	\$ 267,471	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	86,297	86,297	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,522	173,522	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,579	1,579	31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,115	123,115	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>	61,482	61,482	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 713,467	\$ 713,466	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,229,403	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,229,403	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 713,467	\$ 2,942,869	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,980,431	\$ 70,721	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,693,898	\$ 3,013,590	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,969,688	1
2	Restatements (describe):		2
3	<u>State Replacement Tax</u>	(12,611)	3
4	<u>Rounding</u>	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,957,079	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	508,352	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	(1,485,000)	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)	\$ (976,648)	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)	\$ 1,980,431	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Arbour Health Care Center# 0034736Report Period Beginning: 01/01/18Ending: 12/31/18**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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,213,554	1
2	Discounts and Allowances for all Levels	(215,076)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,998,478	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,778	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 267,778	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	14,902	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,074	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,586	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,562	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,455	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,455	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	32,718	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,718	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,334,991	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,038,530	31
32	Health Care	1,692,917	32
33	General Administration	1,276,982	33
B. Capital Expense			
34	Ownership	425,748	34
C. Ancillary Expense			
35	Special Cost Centers	140,897	35
36	Provider Participation Fee	251,565	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,826,639	40
41	Income before Income Taxes (line 30 minus line 40)**	508,352	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 508,352	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,676,777	44
45	Private Pay - Net Inpatient Revenue	7,675	45
46	Medicare - Net Inpatient Revenue	314,026	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,998,478	49

* 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.

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

Facility Name & ID Number **Arbour Health Care Center**

0034736

Report Period Beginning: **01/01/18**

Ending:

12/31/18

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	1,976	2,088	\$ 93,794	\$ 44.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,226	12,201	362,438	29.71	3
4	Licensed Practical Nurses	12,813	14,112	376,424	26.67	4
5	CNAs & Orderlies	33,705	36,360	462,668	12.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,923	2,076	25,923	12.49	8
9	Activity Director	1,616	1,692	25,308	14.96	9
10	Activity Assistants	3,784	4,232	54,267	12.82	10
11	Social Service Workers	4,309	4,543	83,222	18.32	11
12	Dietician					12
13	Food Service Supervisor	1,751	1,912	35,491	18.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,532	15,285	194,865	12.75	15
16	Dishwashers					16
17	Maintenance Workers	5,931	6,505	103,670	15.94	17
18	Housekeepers	8,407	9,605	123,739	12.88	18
19	Laundry	5,756	6,309	79,329	12.57	19
20	Administrator	1,872	1,936	97,727	50.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,068	5,812	85,277	14.67	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 Care(specify)					32
33	Other(specify) <u>See Attached</u>	3,687	3,911	128,143	32.76	33
34	TOTAL (lines 1 - 33)	117,356	128,579	\$ 2,332,285 *	\$ 18.14	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	\$ 6,689	01-03	35
36	Medical Director	Monthly	23,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,061	10-03	39
40	Physical Therapy Consultant	Monthly	523	10a-03	40
41	Occupational Therapy Consultant	Monthly	895	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	528	11-03	44
45	Social Service Consultant	5	264	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5	\$ 41,360		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

Facility Name & ID Number Arbour Health Care Center# 0034736

Report Period Beginning:

01/01/18Ending: 12/31/18**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. HCCI \$10,692
- (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. \$ 17,338 Line 10
- (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. \$ 251,565
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 37,559 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees