		FOR BHF USE					

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0019471

Facility Name: The Arbor

Address: 535 South Elm (Number) Itasca (City) 60143 (Zip Code)

County: DuPage

Telephone Number: (630) 773-9416 **Fax #** (630) 773-9434

HFS ID Number: [redacted]

Date of Initial License for Current Owners: 08/06/75

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address: mike.martin@mcgladrey.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,885	1,885	8
9	SNF/PED					9
10	ICF	21,694	5,779		27,473	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,694	5,779	1,885	29,358	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.86%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 08/06/1975

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 1,885

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	244,943	29,105	6,962	281,010		281,010		281,010			1
2	Food Purchase		170,617		170,617		170,617		170,617			2
3	Housekeeping	11,610		227,395	239,005		239,005		239,005			3
4	Laundry	1,339			1,339		1,339		1,339			4
5	Heat and Other Utilities			111,993	111,993		111,993		111,993			5
6	Maintenance	8,980		45,480	54,460		54,460		54,460			6
7	Other (specify):*											7
8	TOTAL General Services	244,943	221,651	391,830	858,424		858,424		858,424			8
	B. Health Care and Programs											
9	Medical Director	21,600			21,600		21,600		21,600			9
10	Nursing and Medical Records	1,797,043	122,742	25,873	1,945,658		1,945,658		1,945,658			10
10a	Therapy	268,950			268,950		268,950		268,950			10a
11	Activities	112,721	3,600	1,296	117,617		117,617		117,617			11
12	Social Services	44,990		2,520	47,510		47,510		47,510			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,954,754	126,342	320,239	2,401,335		2,401,335		2,401,335			16
	C. General Administration											
17	Administrative	123,231			123,231		123,231		123,231			17
18	Directors Fees											18
19	Professional Services			84,332	84,332		84,332		84,332			19
20	Dues, Fees, Subscriptions & Promotions			15,988	15,988		15,988	(2,576)	13,412			20
21	Clerical & General Office Expenses	154,642	30,513	20,186	205,341		205,341	(14,219)	191,122			21
22	Employee Benefits & Payroll Taxes			349,425	349,425		349,425		349,425			22
23	Inservice Training & Education			5,905	5,905		5,905		5,905			23
24	Travel and Seminar			1,893	1,893		1,893		1,893			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			136,799	136,799		136,799		136,799			26
27	Other (specify):*											27
28	TOTAL General Administration	277,873	30,513	614,528	922,914		922,914	(16,795)	906,119			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,477,570	378,506	1,326,597	4,182,673		4,182,673	(16,795)	4,165,878			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 The Arbor #0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,265	33,265		33,265	91,228	124,493			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,097	73,097		73,097	259,597	332,694			32
33	Real Estate Taxes							66,254	66,254			33
34	Rent-Facility & Grounds			482,880	482,880		482,880	(482,880)				34
35	Rent-Equipment & Vehicles							8,340	8,340			35
36	Other (specify):* Mortgage Ins.							26,431	26,431			36
37	TOTAL Ownership			589,242	589,242		589,242	(31,030)	558,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	100,911			100,911		100,911		100,911			39
40	Barber and Beauty Shops	4,033			4,033		4,033		4,033			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee	78,840			78,840		78,840		78,840			42
43	Other (specify):* Non-Allowable Cos	154,154			154,154		154,154	(154,154)				43
44	TOTAL Special Cost Centers		100,911	237,027	337,938		337,938	(154,154)	183,784			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,477,570	479,417	2,152,866	5,109,853		5,109,853	(201,979)	4,907,874			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

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,939	30		9
10	Interest and Other Investment Income	(122)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(627)	43		13
14	Non-Care Related Interest	(17,172)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,219)	21		18
19	Entertainment	(99)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(133,363)	43		24
25	Fund Raising, Advertising and Promotional	(9,856)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(5,366)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (175,885)		$	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 Amount	2 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)	(26,094)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (26,094)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (201,979)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor

ID# 0019471

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Labs-Part A	$ (866)	43	1
2	Disallow Franchise Tax	(250)	43	2
3	Disallow Non-Allowable Dues	(2,576)	20	3
4	Offset Vending Machine Revenue	(2,218)	43	4
5	Disallow Amortization Expense	(446)	32	5
6	Disallow X-Ray	1,215	43	6
7	Disallow Trust Fees	(225)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,366)		49

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John C. Florina, Sr.	30	N/A		Itasca Shelter	Itasca	Lessor
Duane Jacobson	30			Care, LLC		
Charles Ricci	30					
John C. Florina, Jr.	10					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Itasca Shelter Care, LLC		$ 87,490	$ 87,490	1
2	V	32	Interest	174	Itasca Shelter Care, LLC		276,310	276,136	2
3	V	32	Interest Income		Itasca Shelter Care, LLC				3
4	V	33	Real Estate Taxes		Itasca Shelter Care, LLC		66,254	66,254	4
5	V	34	Rental Income	482,880	Itasca Shelter Care, LLC			(482,880)	5
6	V	36	MIP Insurance		Itasca Shelter Care, LLC		26,431	26,431	6
7	V	43	Franchise Tax		Itasca Shelter Care, LLC		250	250	7
8	V	43	Trust Fee		Itasca Shelter Care, LLC		225	225	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 483,054			$ 456,960	$ * (26,094)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Florina, Sr.	Owner	Board	30.00	None	5	8.00	Director Fees	$ 0	L18, C3	1
2	Duane Jacobson	Owner	Board	30.00	None	5	8.00	Director Fees	0	L18, C3	2
3	Charles Ricci	Owner	Board	30.00	None	5	8.00	Director Fees	0	L18, C3	3
4	John Florina, Jr.	Asst Admin / Admin	Administration	10.00	None	40	100.00	Salary	103,263	L17, C1	4
5	Daniel Florina	Contractor	Maintenance	0.00	None	Varied	Varied	Contract	1,040	L6, C3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 104,303		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 The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X]

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

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	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 The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		X	Mortgage	$28,440.00	3/1/05	$ 5,089,300	$ 4,785,680	3/1/40	0.0583	$ 277,511	1
2	First Chicago Bank & Trust		X	Mortgage	$5,482.00	5/1/06	707,351	652,433	5/1/31	Variable	52,650	2
3	Itasca Bank & Trust Company		X	Line of Credit	Interest Only	6/24/10	100,000	100,000	6/24/11	0.0525	2,829	3
4												4
5												5
	Working Capital											
6	Shareholder Loans	X		Working Capital	None	12/31/03		436,674	on demand	0.0500	17,172	6
7												7
8												8
9	TOTAL Facility Related				$33,922.00		$ 5,896,651	$ 5,974,787			$ 350,162	9
	B. Non-Facility Related*											
10												10
11								Nonallowable Shareholder Interest			(17,172)	11
12								Interest Income Offset			(122)	12
13								Interest Income Offset-RE Entity			(174)	13
14	TOTAL Non-Facility Related						$	$			$ (17,468)	14
15	TOTALS (line 9+line14)						$ 5,896,651	$ 5,974,787			$ 332,694	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,431 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 72,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 68,254	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,746)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 66,254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	61,791	8
2006	66,582	9
2007	63,011	10
2008	67,325	11
2009		12

2010 Taxes Paid = 68,254
Est. Inc = 3%
Est. 2010 Taxes = 70,301.62. Use 70,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arbor COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0019471

CONTACT PERSON REGARDING THIS REPORT John C. Florina

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-102-040	Nursing Home	$ 1,991.76	$ 1,991.76
2.	03-17-102-041	Nursing Home	$ 32,751.30	$ 32,751.30
3.	03-17-102-045	Nursing Home	$ 33,511.02	$ 33,511.02
4.		$		$
5.		$		$
6.		$		$
7.		$		$
8.		$		$
9.		$		$
10.		$		$
		TOTALS	$ 68,254.08	$ 68,254.08

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	41,000	1975	$ 9,559	1
2	Patient Care	44,336	1992	10,446	2
3	TOTALS	85,336		$ 20,005	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1975	1975	$ 271,012	$	40	$	$	$ 271,012	4
5			1975	1975	187,817		25			187,817	5
6			1975	1975	113,922		20			113,922	6
7			1975	1975	20,747		10			20,747	7
8	76		1993	1993	2,533,506	80,429	40	79,678	(751)	1,447,919	8
	Improvement Type**										
9	Building Improvements			1976	7,019		25			7,019	9
10	Building Improvements			1976	10,352		40			8,671	10
11	Building Improvements			1976	2,620		36			2,226	11
12	Building Improvements			1976	243		10			243	12
13	Building Improvements			1976	608		4			608	13
14	Building Improvements			1987	5,847		20			5,847	14
15	Building Improvements			1988	32,894	1,044	35	940	(104)	21,426	15
16	Building Improvements			1991	32,267	1,024	35	922	(102)	18,122	16
17	Building Improvements			1993	168,024	5,334	40	4,201	(1,133)	77,653	17
18	Building Improvements			1993	21,405	549	39	549		9,657	18
19	Building Improvements			1987	12,923		35	410	410	9,649	19
20	Building Improvements			1988	6,270		35	199	199	4,437	20
21	Building Improvements			1990	21,197		35	672	672	13,507	21
22	Building Improvements			1991	986		35	31	31	603	22
23	Building Improvements			1992	7,503		35	238	238	4,317	23
24	Building Improvements			1993	12,681		40	325	325	5,759	24
25	Building Improvements			1994	3,100		40	79	79	1,314	25
26	Building Improvements			1994	11,175		40	287	287	4,720	26
27	Building Improvements			1995	15,605		10			15,605	27
28	Cabinets			1996	2,768		31	89	89	1,294	28
29	Electrical Fixtures			1996	4,972		31	160	160	2,285	29
30	Cabinets			1996	3,097		31	100	100	1,407	30
31	Building Improvements			1984	12,774		10			12,774	31
32	Building Improvements			1985	7,314		10			7,314	32
33	Building Improvements			1986	4,044		8			4,044	33
34	Building Improvements			1986	1,379		8			1,379	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	
37	Front Door Security System	1997	$ 6,230	$	31	$ 201	$ 201	$ 2,713	37
38	Concrete Pads for Washers	1997	4,430		31	143	143	1,917	38
39	Carpeting	1997	7,271		31	235	235	3,069	39
40	Complete Communications-Nurse Calling System	1998	4,543		31	147	147	1,796	40
41	New Door Opening	1999	1,798		31	58	58	691	41
42	Window Replacement	2000	4,801		31	155	155	1,562	42
43	Roof	2001	3,665		31	118	118	1,143	43
44	Hot Water Heater	2001	2,891		31	93	93	893	44
45	Hot Water Heater	2002	885		31	29	29	255	45
46	Landscape Improvements (sidewalks/walkways)	2002	925		31	30	30	251	46
47	Driveway	2004	2,432		31	78	78	509	47
48	Water Heaters	2005	3,429		31	111	111	646	48
49	Air Conditioners	2005	1,654		31	53	53	284	49
50	Office Rewiring	2006	745		31	24	24	120	50
51	Relocate Bookkeeping Office	2006	8,245		31	266	266	1,330	51
52	Heat Pump Replacement	2006	500		31	16	16	76	52
53	Air Conditioning Unit	2006	7,150		31	231	231	1,057	53
54	Drain Line Replacement	2006	900		31	29	29	119	54
55	Dementia Unit - 2 North	2006	424,851		31	13,705	13,705	57,104	55
56	Carpet South Hallway	2007	11,300		31	365	365	1,428	56
57	Carpet North Hallway	2007	7,200		31	232	232	909	57
58	Carpet Business Office	2007	3,236		31	104	104	321	58
59	New Canopy & Brick Pavers for the Front Entrance	2007	42,810		31	1,381	1,381	5,064	59
60	Replace door, pain & wallpaper S Wing Living Room	2007	5,235		31	169	169	605	60
61	Replace entire nurse call system in north wing	2007	33,240		31	1,072	1,072	3,217	61
62	Oven/range accessories	2008	6,849		10	685	685	1,712	62
63	Insulated window units	2008	4,882		31	157	157	367	63
64	Smoke Detectors	2009	4,020		10	402	402	503	64
65	Dish Room Improvements	2009	4,110		31	133	133	166	65
66	Renovation of tiles, walls, chair rail, partial nurses station	2009	7,179		31	232	232	406	66
67	Nurse Call System	2010	13,914		31	374	374	374	67
68									68
69	To agree to financial statement depreciation			(56,914)			56,914		69
70	TOTAL (lines 4 thru 69)		$ 4,167,391	$ 31,466		$ 109,908	$ 78,442	$ 2,373,904	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 125,742	$ 1,799	$ 14,585	$ 12,786	5-10 Yrs	$ 85,181	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	515,613					515,613	73
74								74
75	TOTALS	$ 641,355	$ 1,799	$ 14,585	$ 12,786		$ 600,794	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2001 Chevrolet Bus	2001	$ 46,219	$	$	$	5	$ 46,219	76
77										77
78										78
79										79
80	TOTALS			$ 46,219	$	$	$		$ 46,219	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,874,970	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,265	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,493	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 91,228	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,020,917	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2008 Chevrolet Suburban	$ 695.00	$ 8,340	17
18					18
19					19
20					20
21	TOTAL		$ 695.00	$ 8,340	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

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

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	6,144	$ 110,433	$	6,144	$ 110,433	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		827	23,150		827	23,150	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		6,634	135,367		6,634	135,367	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				100,911	100,911		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 13,605		$ 268,950	$ 100,911	13,605	$ 369,861	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

STATE OF ILLINOIS

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,348	$ 12,581	1
2	Cash-Patient Deposits	70,900	70,900	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	634,250	634,250	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,960	89,960	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrows		159,147	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 804,458	$ 966,838	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,005	13
14	Buildings, at Historical Cost		3,127,004	14
15	Leasehold Improvements, at Historical Cost	718,682	1,040,387	15
16	Equipment, at Historical Cost	442,295	687,574	16
17	Accumulated Depreciation (book methods)	(537,398)	(3,020,917)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Mortgage Costs	370	29,615	22
23	Other(specify): Deferred Costs-Apts		1,272	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 623,949	$ 1,884,940	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,428,407	$ 2,851,778	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 291,308	$ 285,339	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,000	15,000	28
29	Short-Term Notes Payable	1,189,108	1,189,108	29
30	Accrued Salaries Payable	102,552	102,552	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,047	1,047	31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,000		32
33	Accrued Interest Payable	92,550	115,800	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Sch 17A	275,926	153,497	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,967,491	$ 1,932,343	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,785,679		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)**	$	$ 4,785,679	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,967,491	$ 6,718,022	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (539,084)	$ (3,866,244)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,428,407	$ 2,851,778	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

The Arbor of Itasca, Inc.
FYE 12/31/10
Medicaid Cost Report Workpapers

Schedule 17A

XV. BALANCE SHEET
C. Current Liabilities

Line 36: Other Current Liabilities (Specify)

	Operating	After Consolidation
RENT RECEIVABLE	-	266,920
RENT PAYABLE	(266,920)	(266,920)
DUE TO MEDICARE-BAD DEBTS	(9,006)	(9,006)
DEFERRED MORTGAGE PREMIUM		(125,412)
DUE TO CAMBRIDGE-TAX ADVANCE	-	(19,079)
	(275,926)	(153,497)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (39,675)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (39,675)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(499,408)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (499,409)	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)**	$ (539,084)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,423,988	1
2	Discounts and Allowances for all Levels	(278,055)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,145,933	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	313,844	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 313,844	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	5,478	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	109,003	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	864	19
20	Radiology and X-Ray		20
21	Other Medical Services	27,346	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 142,691	23
	D. Non-Operating Revenue		
24	Contributions	325	24
25	Interest and Other Investment Income***	122	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 447	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,126	28
28a	Vending Machine Income	3,401	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,527	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,610,442	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	858,424	31
32	Health Care	2,401,335	32
33	General Administration	922,914	33
	B. Capital Expense		
34	Ownership	589,242	34
	C. Ancillary Expense		
35	Special Cost Centers	259,098	35
36	Provider Participation Fee	78,840	36
	D. Other Expenses (specify):		
37	Rounding	(3)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,109,850	40
41	**Income before Income Taxes (line 30 minus line 40)****	(499,408)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (499,408)	43

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

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

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

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

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,848	1,832	$ 74,145	$ 40.47	1
2	Assistant Director of Nursing	1,482	1,479	48,547	32.82	2
3	Registered Nurses	11,379	11,435	342,083	29.92	3
4	Licensed Practical Nurses	14,872	14,976	449,808	30.04	4
5	CNAs & Orderlies	64,332	64,516	882,460	13.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,233	2,064	33,199	16.08	9
10	Activity Assistants	7,199	7,263	79,522	10.95	10
11	Social Service Workers	2,123	2,035	44,990	22.11	11
12	Dietician					12
13	Food Service Supervisor	2,278	2,080	40,677	19.56	13
14	Head Cook	6,131	6,147	71,830	11.69	14
15	Cook Helpers/Assistants	14,725	14,747	132,436	8.98	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	3,208	2,080	101,391	48.75	20
21	Assistant Administrator	667	480	21,840	45.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,693	7,739	154,642	19.98	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)					33
34	TOTAL (lines 1 - 33)	140,170	138,873	$ 2,477,570 *	$ 17.84	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	142	$ 6,962	L1, C3	35
36	Medical Director	125	21,600	L9, C3	36
37	Medical Records Consultant	13	750	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	100	975	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,296	L11, C3	44
45	Social Service Consultant	36	2,520	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	439	$ 34,103		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	669	24,148	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	669	$ 24,148		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Annarella	Administrator	0	$ 19,968
John C. Florina, Jr.	Asst Admin / Admin	10	103,263
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 123,231

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MDI Achieve Software	Computer Services	$ 14,468
Stratton, Giganti, Stone & Kopec	Legal	6,852
Ivans	Computer Services	638
Porte Brown LLC	Accounting	7,275
Personnel Planners	U/E Consulting	968
Accurate Computer Consulting	Computer Services	1,593
McGladrey & Pullen	Accounting	45,646
IP Defense	Web Design	2,995
First Chicago Bank & Trust	Banking	148
eHealth Data Solutions	MDS Data	3,749
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 84,332

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,960
Unemployment Compensation Insurance	11,667
FICA Taxes	185,598
Employee Health Insurance	87,080
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,120
TOTAL (agree to Schedule V, line 22, col.8)	$ 349,425

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,911
Health Care Worker Background Check	
(Indicate # of checks performed 121)	1,448
Patient Background Checks	
Illinois Healthcare Association	7,949
Daily Herald	490
Miscellaneous Dues / Subscriptions	60
See Schedule 21A	(436)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,412

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,893
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,893

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULE

F. Dues, Fees, Subscriptions and Promotions

Balance		13,848
DuPage County Health Departme	850	
CLIA Laboratory	150	
Village of Itasca	705	
Secretary of State	377	
Miscellaneous Licenses & Fees	58	
	2,140	
Less : Disallowed PAC Dues	(2,576)	
	(436)	
Total (agrees to Schedule V line 20, col.8)		13,412

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$ $	$	$	$	$	$	$	$	

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association-$7,949**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **51,230** Line **10 (2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **78,840**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.