FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0034736

Facility Name: Arbour Health Care Center

Address: 1512 W Fargo (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 465-7751 **Fax #** (773) 465-2104

HFS ID Number:

Date of Initial License for Current Owners: 12/1/1988

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: Steve Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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**

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	29	Intermediate (ICF)	29	10,585	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,355		568	4,923	8
9	SNF/PED					9
10	ICF	27,247	365		27,612	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,602	365	568	32,535	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.04%

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)
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 [X]

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 12/01/1988

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 568

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Arbour Health Care Center # 0034736 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	169,675	34,029	7,303	211,007		211,007	8,005	219,012			1
2	Food Purchase		183,267		183,267	(38,070)	145,198	(21)	145,177			2
3	Housekeeping	93,982	28,963		122,945		122,945		122,945			3
4	Laundry	69,092	9,188		78,280		78,280		78,280			4
5	Heat and Other Utilities			116,008	116,008		116,008	(2,796)	113,212			5
6	Maintenance	92,702	18,039	59,605	170,346		170,346	(3,504)	166,842			6
7	Other (specify):*							1,380	1,380			7
8	**TOTAL General Services**	425,451	273,486	182,916	881,853	(38,070)	843,784	3,064	846,848			8
	B. Health Care and Programs											
9	Medical Director			20,000	20,000		20,000		20,000			9
10	Nursing and Medical Records	1,264,656	36,924	7,293	1,308,873		1,308,873		1,308,873			10
10a	Therapy	22,266		340	22,606		22,606		22,606			10a
11	Activities	71,460	5,040	2,508	79,008		79,008		79,008			11
12	Social Services	77,893		2,940	80,833		80,833		80,833			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,436,275	41,964	33,081	1,511,320		1,511,320		1,511,320			16
	C. General Administration											
17	Administrative	104,646		261,025	365,671		365,671	(183,763)	181,908			17
18	Directors Fees											18
19	Professional Services			133,555	133,555	(220)	133,335	5,184	138,519			19
20	Dues, Fees, Subscriptions & Promotions			21,089	21,089		21,089	(4,652)	16,437			20
21	Clerical & General Office Expenses	71,185	20,617	38,431	130,233		130,233	33,748	163,981			21
22	Employee Benefits & Payroll Taxes			326,084	326,084	38,070	364,154		364,154			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,259	1,259		1,259	137	1,396			24
25	Other Admin. Staff Transportation			2,235	2,235		2,235	3,209	5,444			25
26	Insurance-Prop.Liab.Malpractice			64,423	64,423		64,423	1,823	66,246			26
27	Other (specify):*							40,101	40,101			27
28	**TOTAL General Administration**	175,831	20,617	848,101	1,044,549	37,850	1,082,399	(104,212)	978,186			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,037,557	336,067	1,064,098	3,437,722	(220)	3,437,502	(101,148)	3,336,354			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: 01/01/15 Ending: 12/31/15

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			6,231	6,231		6,231	117,333	123,564			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							86,031	86,031			32
33	Real Estate Taxes			100,280	100,280	220	100,500	3,657	104,157			33
34	Rent-Facility & Grounds			282,300	282,300		282,300	(282,300)				34
35	Rent-Equipment & Vehicles							5,273	5,273			35
36	Other (specify):*											36
37	TOTAL Ownership			388,811	388,811	220	389,031	(70,006)	319,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,899	91,361	107,260		107,260		107,260			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,128	248,128		248,128		248,128			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		15,899	339,489	355,388		355,388		355,388			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,037,557	351,966	1,792,398	4,181,921		4,181,921	(171,154)	4,010,767			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 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	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	(4,034)	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	64,049	30		9
10	Interest and Other Investment Income	(1,371)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,327)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,156)	20		28
29	Other-Attach Schedule	(35,172)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 17,969		$	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)	(189,123)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (189,123)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (171,154)		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.			$		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

ID# 0034736

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (2,000)	21	1
2	MCA Sequester Reduction	(7,852)	21	2
3	Building Co. - Accounting Fees	(1,250)	19	3
4	Building Co. - Amortization	(1,050)	31	4
5	Building Co. - Illinois Replacement Tax	(2,022)	21	5
6	COPE Dues	(3,528)	20	6
7	Collection Fees	(4,669)	21	7
8	Non-allowable Legal	(600)	19	8
9	Capitalized R&M	(8,620)	06	9
10	Non-Care Depreciation	(3,581)	30	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**	(35,172)		49

Arbour Health Care Center

ID# 0034736

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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:** 01/01/15 **Ending:** 12/31/15

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	(21)											(21)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,034)		1,238									(2,796)	5
6	Maintenance	(8,620)		1,262	3,854								(3,504)	6
7	Other (specify):*				1,380								1,380	7
8	**TOTAL General Services**	(12,675)		2,500	13,239								3,064	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			(238,832)	55,069								(183,763)	17
18	Directors Fees													18
19	Professional Services	(1,850)	1,250	5,559		225							5,184	19
20	Fees, Subscriptions & Promotions	(4,684)		32									(4,652)	20
21	Clerical & General Office Expenses	(20,870)	2,022	52,596									33,748	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			137									137	24
25	Other Admin. Staff Transportation			3,209									3,209	25
26	Insurance-Prop.Liab.Malpractice			1,483		340							1,823	26
27	Other (specify):*			36,494	3,607								40,101	27
28	**TOTAL General Administration**	(27,404)	3,272	(139,322)	58,676	566							(104,212)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,079)	3,272	(136,822)	71,915	566							(101,148)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Arbour Health Care Center** **#** **0034736** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	60,468	54,746	337		1,781							117,333	30
31	Amortization of Pre-Op. & Org.	(1,050)	1,050											31
32	Interest	(1,371)	85,994			1,408							86,031	32
33	Real Estate Taxes					3,657							3,657	33
34	Rent-Facility & Grounds		(282,300)	10,728		(10,728)							(282,300)	34
35	Rent-Equipment & Vehicles			5,273									5,273	35
36	Other (specify):*													36
37	**TOTAL Ownership**	58,047	(140,510)	16,338		(3,882)							(70,006)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	17,969	(137,238)	(120,484)	71,915	(3,316)							(171,154)	45

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [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	34	Rental Income	$ 282,300	Arbour Health Care Center Limited Partnership	100.00%	$	$ (282,300)	1
2	V	19	Accounting Fees		Arbour Health Care Center Limited Partnership	100.00%	1,250	1,250	2
3	V	32	Mortgage Interest		Arbour Health Care Center Limited Partnership	100.00%	85,994	85,994	3
4	V	30	Depreciation		Arbour Health Care Center Limited Partnership	100.00%	54,746	54,746	4
5	V	31	Amortization		Arbour Health Care Center Limited Partnership	100.00%	1,050	1,050	5
6	V	21	Illinois Replacement Tax		Arbour Health Care Center Limited Partnership	100.00%	2,022	2,022	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			$ 145,062	$ * (137,238)	14

*** 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: 01/01/15 Ending: 12/31/15

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. [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)	
15	V	5	UTILITIES	$	STAYCARE MANAGEMENT, LTD.	100.00%	$ 1,238	$ 1,238	15
16	V	6	REPAIRS AND MAINT.				1,262	1,262	16
17	V	17	ADMIN. SALARY				22,193	22,193	17
18	V	19	PROFESSIONAL FEES				5,559	5,559	18
19	V	20	DUES, SUBSCRIPTIONS				32	32	19
20	V	21	CLERICAL & GENERAL				52,596	52,596	20
21	V	24	SEMINARS				137	137	21
22	V	25	ADMIN. STAFF TRAVEL				3,209	3,209	22
23	V	26	INSURANCE				1,483	1,483	23
24	V	27	EMPLOYEE BENEFITS				36,494	36,494	24
25	V	30	DEPRECIATION				337	337	25
26	V	34	BUILDING RENT				10,728	10,728	26
27	V	35	EQUIPMENT RENTAL				5,273	5,273	27
28	V								28
29	V	17	Management Fees	261,025	STAYCARE MANAGEMENT, LTD.			(261,025)	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			$ 261,025			$ 140,541	$ * (120,484)	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: 01/01/15 Ending: 12/31/15

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. [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)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 2,017	$ 2,017	15
16	V	1	DIET. COMP - D. WENGROW				5,988	5,988	16
17	V	6	MAINT. COMP.				3,854	3,854	17
18	V	7	EMP. BEN. - S. WEBSTER				276	276	18
19	V	7	EMP. BEN. - D. WENGROW				620	620	19
20	V	7	EMP. BEN. - MAINT. NON-OWNER				484	484	20
21	V	17	ADMIN. COMP - H. WENGROW				13,358	13,358	21
22	V	17	ADMIN. COMP - J. WEBSTER				41,711	41,711	22
23	V	27	EMP. BEN. - H. WENGROW				932	932	23
24	V	27	EMP. BEN. - J. WEBSTER				2,675	2,675	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			$			$ 71,915	$ * 71,915	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: 01/01/15 Ending: 12/31/15

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. [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)	
15	V	19	PROFESSIONAL FEES	$	DOUBLE YOU REALTY, LLC	100.00%	$ 225	$ 225	15
16	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		340	340	16
17	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC		1,781	1,781	17
18	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		1,408	1,408	18
19	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		3,657	3,657	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	34	RENT	10,728	DOUBLE YOU REALTY, LLC			(10,728)	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			$ 10,728			$ 7,412	$ * (3,316)	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: 01/01/15 Ending: 12/31/15

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 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)	
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: 01/01/15 Ending: 12/31/15

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 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)	
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: 01/01/15 Ending: 12/31/15

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 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)	
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: 01/01/15 Ending: 12/31/15

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 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)	
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: 01/01/15 Ending: 12/31/15

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 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)	
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: 01/01/15 Ending: 12/31/15

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 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)	
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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM J. STERN	21.55%	ABBINGTON REHAB & NURSING CENTER, LTD	ROSELLE	ARBOUR HEALTH CARE CENTER LIMITED PARTNERSHIP		BUILDING CO.	1
2	ESTHER BORENSTEIN	2.53%	ATRIUM HEALTH CARE CENTER, LTD., THE	CHICAGO	DOUBLE YOU REALTY		BUILDING CO.	2
3	HOWARD L. WENGROW	28.62%	HICKORY NURSING PAVILION, INC.	HICKORY HILLS	STAYCARE MANAGEMENT		MANAGEMENT, BOOKKEEI	3
4	JEFFREY J. WEBSTER	31.65%	RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				4
5	MAURICE AARON	4.04%	ZIKAINIM,INC. D/B/A/ ALL AMERICAN NURSING HOME	CHICAGO				5
6	MIRIAM LATINIK	6.06%						6
7	PHYLLIS GARDEN	3.03%						7
8	SID BORENSTEIN	2.53%						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

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Jeffrey Webster	Owner	Administrative	31.65%	See Attached	15.00	21.43%	Alloc. Salary	$ 41,711	17-7	1
2	Howard Wengrow	Owner	Administrative	28.62%	See Attached	5.00	7.69%	Alloc. Salary	13,358	17-7	2
3	Sara Webster	Relative	Dietary		See Attached	1.00	19.96%	Alloc. Salary	2,017	1-7	3
4	Deborah Wengrow	Relative	Dietary		See Attached	1.00	19.96%	Alloc. Salary	5,988	1-7	4
5	Ephraim Braunstein	Relative	Clerical		See Attached	5.81	14.53%	Alloc. Salary	9,414	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	$ 72,488		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: 01/01/15 Ending: 12/31/15

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
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						$	$		$	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: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

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

	1 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	5	UTILITIES	PATIENT DAYS	223,823	6	$ 8,516	$	32,535	$ 1,238	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	223,823	6	8,680		32,535	1,262	2
3	17	ADMIN. SALARY	PATIENT DAYS	223,823	6	152,674	152,674	32,535	22,193	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	38,246		32,535	5,559	4
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	223,823	6	222		32,535	32	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	223,823	6	361,830	307,546	32,535	52,596	6
7	24	SEMINARS	PATIENT DAYS	223,823	6	945		32,535	137	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	223,823	6	22,074		32,535	3,209	8
9	26	INSURANCE	PATIENT DAYS	223,823	6	10,203		32,535	1,483	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	223,823	6	251,057		32,535	36,494	10
11	30	DEPRECIATION	PATIENT DAYS	223,823	6	2,315		32,535	337	11
12	34	BUILDING RENT	PATIENT DAYS	223,823	6	73,800		32,535	10,728	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	223,823	6	36,278		32,535	5,273	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					$ 966,840	$ 460,220		$ 140,541	25

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

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

	1 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	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	1	2,017	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	1	5,988	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	6	3,854	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,381		1	276	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	3,107		1	620	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,328		6	484	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	173,652	173,652	5	13,358	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	194,652	194,652	15	41,711	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,114		5	932	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,481		15	2,675	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 467,329	$ 434,918		$ 71,915	25

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] 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 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	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	1,550		32,535	225	1
2	26	INSURANCE	PATIENT DAYS	223,823	6	2,342		32,535	340	2
3	30	DEPRECIATION	PATIENT DAYS	223,823	6	12,254		32,535	1,781	3
4	32	INTEREST EXPENSE	PATIENT DAYS	223,823	6	9,684		32,535	1,408	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	223,823	6	25,161		32,535	3,657	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					$ 50,991	$		$ 7,412	25

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 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						$	$		$	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: 01/01/15 Ending: 12/31/15

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 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						$	$		$	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: 01/01/15 Ending: 12/31/15

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 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						$	$		$	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: 01/01/15 Ending: 12/31/15

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 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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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: 01/01/15 Ending: 12/31/15

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 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						$	$		$	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: 01/01/15 Ending: 12/31/15

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 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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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: 01/01/15 Ending: 12/31/15

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	MB Financial		X				$	$ 2,545,665			$ 85,994	1
2	Allocated from Double You Realty		X								1,408	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,545,665			$ 87,402	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,371)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,371)	14
15	TOTALS (line 9+line14)						$	$ 2,545,665			$ 86,031	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **None** 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.)**

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arbour Health Care Center # 0034736 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	99,231	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.)	$	101,939	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,708	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	101,230	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.**	$	220	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.	$	104,158	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	84,329	8
	2011	83,978	9
	2012	95,054	10
	2013	96,341	11
	2014	98,281	12

2015 Accrual = $98,281 x 1.03 = $101,230
Allocated from Double You = $3,657

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-306-024-0000	Long Term Care Property	$ 98,281.38	$ 98,281.38
2.	10-35-329-014-0000	Allocation from Double You	$ 25,158.55	$ 3,657.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 123,439.93	$ 101,938.44

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 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 Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [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: _____ 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1996	$ 118,000	1
2	Allocated from Double You		2003	7,268	2
3	TOTALS			$ 125,268	3

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	99		1996	1974	$ 1,995,443	$ 51,165	30	$ 66,515	$ 15,350	$ 1,698,684	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	7,848		20			7,848	9
10	Various			1990	41,826		20			41,826	10
11	Various			1992	21,600		20			21,600	11
12	Various			1993	5,318		20			5,318	12
13	Various			1995	21,420		20	383	383	21,301	13
14	Various			1996	16,100		20	805	805	15,698	14
15	Various			1997	53,433		20	2,672	2,672	48,998	15
16	Various			1998	15,100		20	755	755	13,116	16
17	Various			2000	11,154		20	558	558	8,681	17
18	Various			2001	18,601		20	930	930	13,699	18
19	Various			2002	14,426		20	620	620	10,447	19
20	Various			2003	968		20	48	48	621	20
21	Various			2004	34,368		20	127	127	33,314	21
22	Various			2005	46,614		20	1,521	1,521	40,383	22
23	Various			2006	7,600		20	760	760	6,903	23
24	Various			2007	13,350		20	300	300	11,401	24
25	Various			2008	59,788		20	5,979	5,979	45,611	25
26	Various			2009	36,653		20	3,665	3,665	23,887	26
27	Various			2010	35,088		20	3,334	3,334	22,745	27
28	Various			2011	17,160		20	1,960	1,960	8,677	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		72,691	1,781		1,942	161	25,105	68
69	Financial Statement Depreciation			6,231			(6,231)		69
70	TOTAL (lines 4 thru 69)		$ 2,546,548	$ 59,177		$ 92,874	$ 33,697	$ 2,125,862	70

**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: 01/01/15 Ending: 12/31/15

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		$ 2,546,548	$ 59,177		$ 92,874	$ 33,697	$ 2,125,862	1
2	Fire Alarm System	2012	27,850		20	714	714	2,589	2
3	Piping For Kitchen Sink	2013	2,500		20	64	64	142	3
4	Elevator Sill	2013	4,250		20	109	109	222	4
5	Building Generator	2013	75,000		20	15,000	15,000	31,250	5
6	Gas Pipe Fitting & Valve By Meter Room & Generator	2014	3,500		20	175	175	350	6
7	Two Staircase Rails	2014	3,180		20	159	159	278	7
8	New Doors, Frame & Labels	2014	3,869		20	193	193	339	8
9	Install Fire Pump Annunciator	2014	2,701		20	135	135	225	9
10	Walk-In Cooler Repair	2015	2,983		20	149	149	149	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)		$ 2,672,381	$ 59,177		$ 109,572	$ 50,395	$ 2,161,406	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: 01/01/15 Ending: 12/31/15

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		$ 2,672,381	$ 59,177		$ 109,572	$ 50,395	$ 2,161,406	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
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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)		$ 2,672,381	$ 59,177		$ 109,572	$ 50,395	$ 2,161,406	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: 01/01/15 Ending: 12/31/15

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		$ 2,672,381	$ 59,177		$ 109,572	$ 50,395	$ 2,161,406	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)		$ 2,672,381	$ 59,177		$ 109,572	$ 50,395	$ 2,161,406	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: 01/01/15 Ending: 12/31/15

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		$ 2,672,381	$ 59,177		$ 109,572	$ 50,395	$ 2,161,406	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)		$ 2,672,381	$ 59,177		$ 109,572	$ 50,395	$ 2,161,406	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: 01/01/15 Ending: 12/31/15

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	Buildings:								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.

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2003	69,473	1,781	40	1,781		23,084	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from StayCare	2003	3,218		20	161	161	2,021	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)		$ 72,691	$ 1,781		$ 1,942	$ 161	$ 25,105	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: 01/01/15 Ending: 12/31/15

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		$ 72,691	$ 1,781		$ 1,942	$ 161	$ 25,105	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
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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)		$ 72,691	$ 1,781		$ 1,942	$ 161	$ 25,105	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: 01/01/15 Ending: 12/31/15

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	$ 111,749	$	$ 12,794	$ 12,794	10	$ 67,334	71
72	Current Year Purchases	5,637		564	564	10	564	72
73	Fully Depreciated Assets	365,826				10	365,826	73
74								74
75	TOTALS	$ 483,213	$	$ 13,358	$ 13,358		$ 433,724	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		Allocated from StayCare	2012	$ 4,920	$ 337	$ 633	$ 296	5	$ 2,597	76
77										77
78										78
79										79
80	TOTALS			$ 4,920	$ 337	$ 633	$ 296		$ 2,597	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)	$ 3,285,783	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 59,514	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,563	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 64,049	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,597,727	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 - 2015	$ 8,259	$	$	86
87	Sec 754 - Building - 2015	139,657			87
88					88
89					89
90					90
91	TOTALS	$ 147,916	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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.	/2016	$
13.	/2017	$
14.	/2018	$

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	Allocated from Staycare		$	$ 5,273	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,273	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.

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

   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.

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	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	$		$ 40,465	$		$ 40,465	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,064			9,064	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			40,485			40,485	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 prescrpts				15,899		15,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,347			1,347	13
14	TOTAL			$		$ 91,361	$ 15,899		$ 107,260	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.

STATE OF ILLINOIS

Facility Name & ID Number Arbour Health Care Center **#** 0034736 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 659,916	$ 698,957	1
2	Cash-Patient Deposits	132,448	132,448	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	809,314	809,314	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,299	97,299	6
7	Other Prepaid Expenses	3,151	3,151	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	860	860	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,702,988	$ 1,742,029	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	463,016	463,016	15
16	Equipment, at Historical Cost	226,115	473,615	16
17	Accumulated Depreciation (book methods)	(554,203)	(1,804,310)	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):	913,725	2,975	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,048,653	$ 1,396,655	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,751,641	$ 3,138,684	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 124,135	$ 124,135	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	132,448	132,448	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,878	121,878	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,474	1,474	31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,230	101,230	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	73,813	73,813	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 554,978	$ 554,978	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,545,665	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)**	$	$ 2,545,665	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 554,978	$ 3,100,643	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,196,663	$ 38,041	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,751,641	$ 3,138,684	48

***(See instructions.)**

Facility Name & ID Number Arbour Health Care Center # 0034736 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,209,324	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,209,326	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	284,337	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	(297,000)	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)**	$ (12,663)	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)**	$ 2,196,663	24 *

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

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,415,824	1
2	Discounts and Allowances for all Levels	(158,909)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,256,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	181,085	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 181,085	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	17,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	704	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,105	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,887	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,371	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,371	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,466,258	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	881,853	31
32	Health Care	1,511,320	32
33	General Administration	1,044,549	33
	B. Capital Expense		
34	Ownership	388,811	34
	C. Ancillary Expense		
35	Special Cost Centers	107,260	35
36	Provider Participation Fee	248,128	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,181,921	40
41	**Income before Income Taxes (line 30 minus line 40)****	284,337	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 284,337	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,039,348	44
45	Private Pay - Net Inpatient Revenue	60,225	45
46	Medicare - Net Inpatient Revenue	157,342	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,256,915	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: 01/01/15 Ending: 12/31/15

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	1,680	1,740	$ 75,376	$ 43.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,175	10,605	322,155	30.38	3
4	Licensed Practical Nurses	14,577	15,581	383,501	24.61	4
5	CNAs & Orderlies	32,447	34,734	352,893	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,934	2,071	22,266	10.75	8
9	Activity Director	1,834	2,080	29,873	14.36	9
10	Activity Assistants	3,920	4,332	41,587	9.60	10
11	Social Service Workers	4,320	4,584	77,893	16.99	11
12	Dietician					12
13	Food Service Supervisor	1,728	1,790	26,033	14.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,706	13,916	143,642	10.32	15
16	Dishwashers					16
17	Maintenance Workers	6,408	6,954	92,702	13.33	17
18	Housekeepers	8,544	9,293	93,982	10.11	18
19	Laundry	5,871	6,594	69,092	10.48	19
20	Administrator	2,076	2,289	104,646	45.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,588	4,895	71,185	14.54	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	112	118	1,654	14.02	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,779	4,091	129,077	31.55	33
34	TOTAL (lines 1 - 33)	116,699	125,667	$ 2,037,557 *	$ 16.21	34

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

** See instructions.

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	Monthly	$ 7,303	01-03	35
36	Medical Director	Monthly	20,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,293	10-03	39
40	Physical Therapy Consultant	Monthly	340	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,508	11-03	44
45	Social Service Consultant	61	2,940	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	61	$ 40,384		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				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: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Patty	Administrator	0	$ 104,646
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,646

B. Administrative - Other

Description	Amount
Management Fees-Staycare	$ 261,025
TOTAL (agree to Schedule V, line 17, col. 3)	$ 261,025
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	$ 14,660
See Attached	Legal Fees	83,194
Personnel Planners	Unemployment Consulting	1,000
Ehealth Solutions	Data Processing	15,791
Stay Care Management	Admissions Consultant	16,110
2401 Incorporated Architects	Architectual Services	2,800
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 133,555

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,515
Unemployment Compensation Insurance	19,883
FICA Taxes	145,998
Employee Health Insurance	80,350
Employee Meals	38,070
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	528
Union Pension	16,706
401K Employer	1,889
Christmas Expense	4,215
TOTAL (agree to Schedule V, line 22, col.8)	$ 364,155

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,052
Advertising: Employee Recruitment	1,257
Health Care Worker Background Check	3,240
(Indicate # of checks performed 324)	
Patient Background Checks	
Yellow Pages	1,156
Dues & Subscriptions	7,164
Licences & Permits	3,692
Allocated from Staycare	32
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,156)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,437

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,259
Allocated from Staycare	137
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,396

**See instructions.

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Arbour Health Care Center # 0034736 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $ 10,692.00**

(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. $ **7,752** Line **10-02**

(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. $ **248,128**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **38,070** Has any meal income been offset against related costs? **No** 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? **100% Line 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?
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) 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.