		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0034736

Facility Name: Arbour Health Care Center

Address: 1512 West 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: 12/01/1988

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: Mendel Schneider Telephone Number: (847)933-1274
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 01/01/2020 to 12/31/2020 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)	See Accountant's report Attached
	(Firm Name & Address)	Mendel S. Schneider C.P.A. & Associates 4051 Old Orchard rd, Skokie,Il 60076
	(Telephone)	(847)933-1274 Fax # (847)933-1283

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: 01/01/2020 Ending: 12/31/2020

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 ______

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,620	1
2		Skilled Pediatric (SNF/PED)			2
3	29	Intermediate (ICF)	29	10,614	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,074	28	1,204	20,306	8
9	SNF/PED					9
10	ICF	10,614			10,614	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,688	28	1,204	30,920	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.33%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 1,204

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 Fiscal Year: 12/31

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

Facility Name & ID Number: Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	309,187	26,373	6,921	342,481		342,481	7,102	349,583			1
2	Food Purchase		212,203		212,203		212,203	(240)	211,963			2
3	Housekeeping	177,201	40,151	11,684	229,036		229,036		229,036			3
4	Laundry	124,837	4,862	8,306	138,005		138,005		138,005			4
5	Heat and Other Utilities			144,762	144,762		144,762	1,463	146,225			5
6	Maintenance	87,197		70,474	157,671		157,671	1,736	159,407			6
7	Other (specify):* Security Guards	97,707			97,707		97,707		97,707			7
8	**TOTAL General Services**	796,129	283,589	242,147	1,321,865		1,321,865	10,061	1,331,926			8
	B. Health Care and Programs											
9	Medical Director			23,400	23,400		23,400		23,400			9
10	Nursing and Medical Records	1,689,662	148,346	9,931	1,847,939		1,847,939		1,847,939			10
10a	Therapy											10a
11	Activities	89,475	2,419	1,544	93,438		93,438		93,438			11
12	Social Services	84,376		3,229	87,605		87,605		87,605			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,863,513	150,765	38,104	2,052,382		2,052,382		2,052,382			16
	C. General Administration											
17	Administrative	98,058		347,450	445,508		445,508	(282,223)	163,285			17
18	Directors Fees											18
19	Professional Services			109,930	109,930		109,930	(74,238)	35,692			19
20	Dues, Fees, Subscriptions & Promotions			31,462	31,462		31,462	(1,272)	30,190			20
21	Clerical & General Office Expenses	75,561	31,569	142,369	249,499		249,499	109,124	358,623			21
22	Employee Benefits & Payroll Taxes			430,039	430,039		430,039		430,039			22
23	Inservice Training & Education											23
24	Travel and Seminar			459	459		459	117	576			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			188,912	188,912		188,912	3,290	192,202			26
27	Other (specify):* Allocated benifets							64,176	64,176			27
28	**TOTAL General Administration**	173,619	31,569	1,250,621	1,455,809		1,455,809	(181,026)	1,274,783			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,833,261	465,923	1,530,872	4,830,056		4,830,056	(170,965)	4,659,091			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.

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			46,899	46,899		46,899	29,090	75,989			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							102,422	102,422			32
33	Real Estate Taxes			144,638	144,638		144,638	4,524	149,162			33
34	Rent-Facility & Grounds			282,300	282,300		282,300	(282,300)				34
35	Rent-Equipment & Vehicles							8,405	8,405			35
36	Other (specify):*											36
37	TOTAL Ownership			473,837	473,837		473,837	(137,859)	335,978			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,226	135,527	152,753		152,753		152,753			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			234,727	234,727		234,727		234,727			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		17,226	370,254	387,480		387,480		387,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,833,261	483,149	2,374,963	5,691,373		5,691,373	(308,824)	5,382,549			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: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,943)	30		9
10	Interest and Other Investment Income	(8,693)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(240)	2		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	(32,579)	21		24
25	Fund Raising, Advertising and Promotional	(1,272)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,532)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (72,259)		$	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)	(236,565)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (236,565)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (308,824)		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: 01/01/2020
Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	7,102	0	0	0	0	0	0	0	0	7,102	1
2	Food Purchase	(240)	0	0	0	0	0	0	0	0	0	0	(240)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,463	0	0	0	0	0	0	0	0	1,463	5
6	Maintenance	0	0	1,736	0	0	0	0	0	0	0	0	1,736	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(240)	0	10,301	0	0	0	0	0	0	0	0	10,061	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(282,223)	0	0	0	0	0	0	0	0	(282,223)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(75,146)	908	0	0	0	0	0	0	0	(74,238)	19
20	Fees, Subscriptions & Promotions	(1,272)	0	0	0	0	0	0	0	0	0	0	(1,272)	20
21	Clerical & General Office Expenses	(42,111)	61	151,018	156	0	0	0	0	0	0	0	109,124	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	117	0	0	0	0	0	0	0	0	117	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,381	909	0	0	0	0	0	0	0	3,290	26
27	Other (specify):*	0	0	64,176	0	0	0	0	0	0	0	0	64,176	27
28	**TOTAL General Administration**	(43,383)	61	(139,677)	1,973	0	0	0	0	0	0	0	(181,026)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,623)	61	(129,376)	1,973	0	0	0	0	0	0	0	(170,965)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	(19,943)	49,033	0	0	0	0	0	0	0	0	0	29,090	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,693)	111,033	0	82	0	0	0	0	0	0	0	102,422	32
33	Real Estate Taxes	0	0	0	4,524	0	0	0	0	0	0	0	4,524	33
34	Rent-Facility & Grounds	0	(282,300)	18,064	(18,064)	0	0	0	0	0	0	0	(282,300)	34
35	Rent-Equipment & Vehicles	0	0	8,405	0	0	0	0	0	0	0	0	8,405	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,636)	(122,234)	26,469	(13,458)	0	0	0	0	0	0	0	(137,859)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(72,259)	(122,173)	(102,907)	(11,485)	0	0	0	0	0	0	0	(308,824)	45

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Page 6 Supplemental		See Page 6 Supplemental		See Page 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 282,300	Arbour Health Care Real Estate LLC	100.00%	$	$ (282,300)	1
2	V	32	Mortgage Interest		Arbour Health Care Real Estate LLC		111,033	111,033	2
3	V	30	Depreciation		Arbour Health Care Real Estate LLC		49,033	49,033	3
4	V	21	Office		Arbour Health Care Real Estate LLC		61	61	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 282,300			$ 160,127	$ * (122,173)	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: 01/01/2020 Ending: 12/31/2020

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	STAYCARE MANAGEMENT	100.00%	$ 1,463	$ 1,463	15
16	V	6	Repairs & Maintenance		STAYCARE MANAGEMENT	100.00%	1,736	1,736	16
17	V	17	Admin Salary-H Wengrow		STAYCARE MANAGEMENT	100.00%	31,266	31,266	17
18	V	17	Admin Salary-J Webster		STAYCARE MANAGEMENT	100.00%	33,961	33,961	18
19	V	19	Professional Fees		STAYCARE MANAGEMENT	100.00%	444	444	19
20	V	21	Clerical Salaries		STAYCARE MANAGEMENT	100.00%	180,772	180,772	20
21	V	21	Office Supplies		STAYCARE MANAGEMENT	100.00%	11,395	11,395	21
22	V	26	Insurance		STAYCARE MANAGEMENT	100.00%	2,381	2,381	22
23	V	27	Health Insurance		STAYCARE MANAGEMENT	100.00%	38,979	38,979	23
24	V	1	Dietary Salary-S Webster		STAYCARE MANAGEMENT	100.00%	1,789	1,789	24
25	V	1	Dietary Salary-D Wengrow		STAYCARE MANAGEMENT	100.00%	5,313	5,313	25
26	V	24	Seminars		STAYCARE MANAGEMENT	100.00%	117	117	26
27	V	34	Rent		STAYCARE MANAGEMENT	100.00%	18,064	18,064	27
28	V	27	Payroll taxes		STAYCARE MANAGEMENT	100.00%	16,065	16,065	28
29	V	27	Employee Benifets		STAYCARE MANAGEMENT	100.00%	9,132	9,132	29
30	V	35	Equipment Rental -Auto		STAYCARE MANAGEMENT	100.00%	8,405	8,405	30
31	V								31
32	V	17	Management Fees	347,450	STAYCARE MANAGEMENT	100.00%		(347,450)	32
33	V	19	Administrative Consultant	75,590	STAYCARE MANAGEMENT	100.00%		(75,590)	33
34	V	21	Admissions Director	17,630	STAYCARE MANAGEMENT	100.00%		(17,630)	34
35	V	21	Reimbursement Consultant	23,519	STAYCARE MANAGEMENT	100.00%		(23,519)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 464,189			$ 361,282	$ * (102,907)	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: 01/01/2020 Ending: 12/31/2020

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	DOUBLE YOU REALTY	100.00%	$ 908	$ 908	15
16	V	26	Insurance		DOUBLE YOU REALTY		909	909	16
17	V	30	Depreciation		DOUBLE YOU REALTY		0		17
18	V	32	Interest Expense		DOUBLE YOU REALTY		82	82	18
19	V	33	Real Estate Taxes		DOUBLE YOU REALTY		4,524	4,524	19
20	V	21	Office Supplies		DOUBLE YOU REALTY		156	156	20
21	V								21
22	V	34	Rent	18,064	DOUBLE YOU REALTY			(18,064)	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			$ 18,064			$ 6,579	$ * (11,485)	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: 01/01/2020 Ending: 12/31/2020

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 Stern	21.55	Hickory Nursing Pavilion	Hickory Hills	Arbour Health Care R	Chicago	Bldg Rental	1
2	Esther Borenstein	2.53	Atrium Health Care Center, LTD	Chicago	Double You Realty	Lincolmnwood	Building Company	2
3	Howard wengrow	28.62	Abbington Rehan & Nursing, LTD	Roselle	Staycare Management	Lincolnwood	Management	3
4	Jeffrey Webster	31.65	Zikanim, INC D/B/A All American Nursing Hom	Chicago				4
5	Maurice Aaron	4.04						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: 01/01/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Jeffrey Webster	Owner	Administartive	50.00	157,800	8	20.00		$ 33,961	17-07	1
2	Howard Wengrow	Owner	Administartive	50.00	145,279	8	20.00		31,266	17-07	2
3	Sara Webster	Relative	Dietary		8,315	8	20.00		1,789	01-07	3
4	Deborah Wengrow	Relative	Dietary		24,687	8	20.00		5,313	01-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 72,329		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: 01/01/2020 Ending: 2/31/2020

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
Street Address	3737 W ARTHUR AVE
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	Number of Beds	559	5	$ 8,261	$	99	$ 1,463	1
2	6	Repairs & Maintenance	Number of Beds	559	5	9,800		99	1,736	2
3	17	Admin Salary-H Wengrow	Number of Beds	559	5	176,545	176,545	99	31,266	3
4	17	Admin Salary-J Webster	Number of Beds	559	5	191,761	191,761	99	33,961	4
5	19	Professional Fees	Number of Beds	559	5	2,509		99	444	5
6	21	Clerical Salaries	Number of Beds	559	5	1,020,725	1,020,725	99	180,772	6
7	21	Office Supplies	Number of Beds	559	5	64,344		99	11,395	7
8	26	Insurance	Number of Beds	559	5	13,444		99	2,381	8
9	27	Health Insurance	Number of Beds	559	5	220,093		99	38,979	9
10	1	Dietary Salary-S Webster	Number of Beds	559	5	10,104	10,104	99	1,789	10
11	1	Dietary Salary-D Wengrow	Number of Beds	559	5	30,000	30,000	99	5,313	11
12	24	Seminars	Number of Beds	559	5	660		99	117	12
13	34	Rent	Number of Beds	559	5	102,000		99	18,064	13
14	27	Payroll taxes	Number of Beds	559	5	90,708		99	16,065	14
15	27	Employee Benifets	Number of Beds	559	5	51,563		99	9,132	15
16	35	Equipment Rental -Auto	Number of Beds	559	5	47,460		99	8,405	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,039,977	$ 1,429,135		$ 361,282	25

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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
Street Address: 3737 W Arthur
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	Number of Beds	559	5	$ 5,127	$	99	$ 908	1
2	26	Insurance	Number of Beds	559	5	5,130		99	909	2
3	30	Depreciation	Number of Beds	559	5					3
4	32	Interest Expense	Number of Beds	559	5	465		99	82	4
5	33	Real Estate Taxes	Number of Beds	559	5	25,547		99	4,524	5
6	21	Office Supplies	Number of Beds	559	5	881		99	156	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					$ 37,150	$		$ 6,579	25

Facility Name & ID Number: Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Fifth Third Bank		X	Mortgage			$	$ 2,054,994			$ 111,033	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Double you realty										82	6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,054,994			$ 111,115	9
	B. Non-Facility Related*											
10	Interest Income										(8,693)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,693)	14
15	TOTALS (line 9+line14)						$	$ 2,054,994			$ 102,422	15

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

* 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: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	142,602	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.)	$	142,199	2
3. Under or (over) accrual (line 2 minus line 1).	$	(403)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	145,043	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ______ For ______ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	149,162	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	101,749	8
2016	111,212	9
2017	119,530	10
2018	139,807	11
2019	142,199	12

142602 X 1.02=145043

Allocated from Double You Realty 4524

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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 Facility	$ 142,198.58	$ 142,198.58
2.	10-35-329-014-0000	Allocated from Double You Realty	$ 25,547.37	$ 4,524.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 167,745.95	$ 146,722.58

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1996	$ 118,000	1
2	ALLOCATED FROM DOUBLE YOU REALTY LLC			7,663	2
3	TOTALS			$ 125,663	3

Facility Name & ID Number **Arbour Health Care Center** # **0034736** Report Period Beginning: **01/01/2020** Ending: **12/31/2020**

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	$ 49,033	30	$ 30,699	$ (18,334)	$ 1,995,443	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	7,848		20			7,789	9
10	Various			1990	7,291		20			7,286	10
11	Various			1992	21,600		20			21,600	11
12	Various			1993	5,318		20			5,225	12
13	Various			1995	21,420		20			21,301	13
14	Various			1996	16,100		20			16,100	14
15	Various			1997	53,433		20			53,429	15
16	Various			1998	15,100		20			15,100	16
17	Various			2000	11,154		20	242	242	11,154	17
18	Various			2001	18,601		20	930	930	18,349	18
19	Various			2002	14,426		20	620	620	13,546	19
20	Various			2003	968		20	48	48	862	20
21	Various			2004	34,368		20	127	127	33,948	21
22	Various			2005	46,614		20	686	686	43,813	22
23	Various			2006	7,600		20			7,600	23
24	Various			2007	13,350		20	300	300	12,900	24
25	Various			2008	59,788		20	2,220	2,220	64,228	25
26	Various			2009	36,653		20			38,548	26
27	Various			2010	35,088		20	1,143	1,143	35,088	27
28	Various			2011	17,160		20	1,170	1,170	17,160	28
29	Various			2012	27,850		20	714	714	6,159	29
30	Various			2013	81,750		20			89,806	30
31	Various			2014	13,250		20	663	663	4,505	31
32											32
33											33
34											34
35	Financial Statement Depreciation					46,899			(46,899)		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: 01/01/2020 Ending: 12/31/2020

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	Walk In Cooler Repair	2015	$ 2,983	$	20	$ 149	$ 149	$ 795	37
38	New water Heater And Installation	2016	10,410		20	868	868	3,977	38
39	New Sidewalk & Concrete Staircase	2016	23,025		20	2,303	2,303	10,362	39
40	Elevator Telephone	2016	2,500		20	71	71	344	40
41	Removal of Cast Iron, Insulated Piping	2016	3,800		20	109	109	535	41
42	Rental Fee of Modular ramp, Installation fee	2016	2,924		20	84	84	384	42
43	Sewer work	2016	3,500		20	100	100	433	43
44	Walk in Freezer Repair	2016	2,844		20	81	81	338	44
45	Installation of Additional Devices to Fire Alarm System	2016	3,400		20	97	97	461	45
46	Elevator Shunt Breaker Installation	2016	6,150		20	308	308	1,462	46
47	Replace Iron trap for Drain	2016	2,600		20	130	130	650	47
48	State Water Heater	2017	10,660		20	533	533	1,910	48
49	Brickwork Around Facility	2017	164,550		20	8,228	8,228	29,483	49
50	Gravel Stop over existing roof	2017	16,150		20	808	808	2,895	50
51	Material Fabrication/Paint/Install Handrails-Landing/Balcony	2017	3,956		20	198	198	726	51
52	Dry System and Sprinklers Under Exterior Canopy	2018	6,125		20	306	306	714	52
53	Repair of Door Holder System	2018	4,589		20	229	229	515	53
54	Repairs to Heating Boilers and 3rd Floor Boiler Pump	2018	2,913		20	146	146	304	54
55	Elevator modernization includes new controller & landing	2019	57,500		20	2,875	2,875	5,750	55
56	syste, new emergency power,new door operators,new electrical								56
57	eye,new alarm,new hall stations for 4 landings								57
58	Install RPZ's:2 for washmachine,1 for dishwasher,1 for	2019	5,000		20	250	250	500	58
59	coffee machine, and 1 for icemaker								59
60	Install elevator recall system,install 3 relays,4 smoke detectors	2019	6,705		20	335	335	670	60
61	install 1 ton mini split system	2019	7,500		20	375	375	750	61
62	Installed a ground for 100 amp disconnect to elevator	2019	12,540		20	627	627	1,254	62
63	installed control panel for elevator,install a 110 volt 15 amp								63
64	line for elevator lights								64
65	installed new heat pump	2019	5,629		20	281	281	562	65
66	new water heater left side	2019	9,667		20	483	483	966	66
67	Replace Baseboard Radiators	2020	3,627		20	181	181	181	67
68	5 Install 5 dedicated outlets to supply A/c rooms 309-313	2020	3,250		20	163	163	163	68
69	Install new power supply and maglocks for front doors	2020	4,215		20	211	211	211	69
70	TOTAL (lines 4 thru 69)		$ 2,950,885	$ 95,932		$ 60,091	$ (35,841)	$ 2,608,234	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: 01/01/2020 Ending: 12/31/2020

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		$ 2,950,885	$ 95,932		$ 60,091	$ (35,841)	$ 2,608,234	1
2	Installation of Surveilance Cameras for facility	2020	4,680		20	234	234	234	2
3									3
4									4
5									5
6									6
7									7
8	Related parties								8
9	Buildings:								9
10	Allocated from Double You realty	2003	73,252		35	1,878	1,878	33,732	10
11									11
12									12
13									13
14	Leasehold Improvements:								14
15	Allocated from StayCare Management	2016	3,985		20	199	199	929	15
16	Allocated from StayCare Management	2003	3,393		20	170	170	2,980	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)		$ 3,036,195	$ 95,932		$ 62,572	$ (33,360)	$ 2,646,109	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: 01/01/2020 Ending: 12/31/2020

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	$ 121,989	$	$ 12,199	$ 12,199	10	$ 117,008	71
72	Current Year Purchases	12,175		1,218	1,218	10	1,218	72
73	Fully Depreciated Assets	382,166				10	382,166	73
74								74
75	TOTALS	$ 516,330	$	$ 13,417	$ 13,417		$ 500,392	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 management		$ 5,187	$	$	$		$ 5,187	76
77										77
78										78
79										79
80	TOTALS			$ 5,187	$	$	$		$ 5,187	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)	$ 3,683,375	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 95,932	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,989	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,943)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,151,688	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number: Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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 mgmt		$	$ 8,405	17
18					18
19					19
20					20
21	TOTAL		$	$ 8,405	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: 01/01/2020 Ending: 12/31/2020

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 58,134	$		$ 58,134	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,541			4,541	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			72,852			72,852	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				17,226		17,226	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 135,527	$ 17,226		$ 152,753	14

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

Facility Name & ID Number Arbour Health Care Center # 0034736 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 1,429,340	$ 2,017,869	1
2	Cash-Patient Deposits	135,951	135,951	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	587,140	587,140	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,398	45,398	6
7	Other Prepaid Expenses	91,134	91,134	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,283,751	5,169	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,572,714	$ 2,882,661	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	828,242	828,242	15
16	Equipment, at Historical Cost	247,133	494,633	16
17	Accumulated Depreciation (book methods)	(761,766)	(2,280,654)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 313,609	$ 1,303,580	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,886,323	$ 4,186,241	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 198,624	$ 198,624	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	135,951	135,951	28
29	Short-Term Notes Payable	491,387	491,387	29
30	Accrued Salaries Payable	127,750	127,750	30
31	Accrued Taxes Payable (excluding real estate taxes)	738	738	31
32	Accrued Real Estate Taxes(Sch.IX-B)	145,043	145,043	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,099,493	$ 1,099,493	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,144,439	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)**	$	$ 2,144,439	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,099,493	$ 3,243,932	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,786,830	$ 942,309	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,886,323	$ 4,186,241	48

*(See instructions.)

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,102,686	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,102,686	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	684,144	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 684,144	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)**	$ 2,786,830	24 *

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

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 5,694,205	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,694,205	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,693	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,693	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Stimulus Income	672,619	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 672,619	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,375,517	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,321,865	31
32	Health Care	2,052,382	32
33	General Administration	1,455,809	33
	B. Capital Expense		
34	Ownership	473,837	34
	C. Ancillary Expense		
35	Special Cost Centers	152,753	35
36	Provider Participation Fee	234,727	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,691,373	40
41	**Income before Income Taxes (line 30 minus line 40)****	684,144	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 684,144	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,888,249	44
45	Private Pay - Net Inpatient Revenue	14,375	45
46	Medicare - Net Inpatient Revenue	728,654	46
47	Other-(specify) B Income	62,927	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,694,205	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, 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: 01/01/2020 Ending: 12/31/2020

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,048	2,296	$ 97,431	$ 42.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,959	10,842	341,471	31.50	3
4	Licensed Practical Nurses	19,612	21,178	607,528	28.69	4
5	CNAs & Orderlies	35,562	38,998	604,531	15.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,171	2,457	38,701	15.75	8
9	Activity Director	1,185	1,235	19,828	16.06	9
10	Activity Assistants	3,859	4,504	69,647	15.46	10
11	Social Service Workers	4,260	4,606	84,376	18.32	11
12	Dietician					12
13	Food Service Supervisor	1,830	2,006	39,694	19.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,261	14,888	269,493	18.10	15
16	Dishwashers					16
17	Maintenance Workers			87,197		17
18	Housekeepers	9,946	11,689	177,201	15.16	18
19	Laundry	6,417	7,133	124,837	17.50	19
20	Administrator	1,760	2,040	98,058	48.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,566	5,139	75,561	14.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Security Guards	5,931	6,339	97,707	15.41	33
34	TOTAL (lines 1 - 33)	122,367	135,350	$ 2,833,261 *	$ 20.93	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,921	1-3	35
36	Medical Director	Monthly	23,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,104	10-3	39
40	Physical Therapy Consultant	22	1,099	10-3	40
41	Occupational Therapy Consultant	2	93	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	129	10-3	43
44	Activity Consultant	33	1,544	11-3	44
45	Social Service Consultant	67	3,229	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	126	$ 44,519		49

C. CONTRACT NURSES

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

Facility Name & ID Number Arbour Health Care Center # 0034736 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Jacobson	Adminstartive		$ 69,236
Deb Vege	Adminstartive		28,822
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 98,058

B. Administrative - Other

Description	Amount
Staycare Management	$ 347,450
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 347,450

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 12,000
staycare Management		75,590
Personnel Planners		563
Cukierski & Cochran		1,036
Ohagin Meyer	Legal	5,812
Gallagher Basset		3,957
Much Shelist		10,972
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 109,930

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,747
Unemployment Compensation Insurance	11,776
FICA Taxes	220,054
Employee Health Insurance	105,292
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	719
Union Pension	26,451
TOTAL (agree to Schedule V, line 22, col.8)	$ 430,039

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		$ 1,990
Advertising: Employee Recruitment		2,006
Health Care Worker Background Check		
(Indicate # of checks performed)		
Patient Background Checks	336	3,693
Misc License		4,689
Misc Dues		17,812
Advertising		1,272
Less: Public Relations Expense		( )
Non-allowable advertising		(1,272)
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 30,190

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	459
Allocated from Staycare	117
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 576

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI 17812**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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?

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,209** Line **10**

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

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

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **234,727**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **no**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
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. $ **0**

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

(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.