

Date: 07/01/2005
To: Administrator/Cost Report Preparer
From: Bureau of Health Finance
Re: 2005 Long Term Care Cost Report and Instructions

This year the cost report will be available by download from the Internet or by Email. If you require a disk, please call Fred Sosman at 217-782-1630. The web site for the download of the cost report file and instructions is <http://www.hfs.illinois.gov/costreports/>. Click on the Nursing Home and ICF/DD link. Next right-click on the "Excel version" and select, "Save Target As". Then save the file on your computer system in the location where you want it. Next, right-click on the instructions file and select "Save Target As". Then save the file on your computer system.

When you have completed the cost report, send in the completed cost report file by email, CD or disk. **The EMAIL address for sending in the Excel file is aidd7608@mail.idpa.state.il.us.** A signed paper copy must be sent in also. In order to provide for the efficient and accurate processing of any 7/01/06 - 6/30/07 Medicaid rates, the completed Excel cost report file must be sent in at the same time as the paper copy of the cost report.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2005. It is due on September 30, 2005, or 90 days after the close of the facility's fiscal year, whichever comes later. Please refer to the instructions for the remainder of the filing requirements.

Please use the 2005 cost report file and instructions. Printed copies of the report from the 2004 cost report or earlier files will NOT be accepted. In order to print the instructions on legal paper, open the Instr05.pdf file. Then click File-Page Setup. Change the paper size to legal and click OK. Otherwise, the instructions will print on letter size paper. The type may be a little small if letter size is used.

IMPORTANT NOTICE for Those Facilities Receiving a Calendar 2004 Real Estate Tax Bill: Located after page 10 of the cost report on the worksheet named "RE_TAX" is the "2004 Long Term Care Real Estate Tax Statement." As in previous years, the real estate tax statement is being included in the cost report. A separate notice requesting the submittal of this statement and the calendar 2004 tax bill will not be sent. Please complete the "2004 Long Term Care Real Estate Tax Statement" and send it to our office along with the copies of the calendar 2004 real estate tax bills as an attachment to the fiscal 2005 cost report. Please Note: Copies of the original tax bills must be provided.

If both the "2004 Long Term Care Real Estate Tax Statement" and the corresponding tax bills are not included with the 2005 cost report, the Medicaid rate will not include a component for real estate taxes. Additionally, the cost report will not be considered complete and timely filed and may be subject to Medicaid payments being withheld.

Cost Report File

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility. Ensure that the 7 digit IDPH ID# is correct.) When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter "various" or other text in columns 2 or 3.

Attachments

Please include all explanations, additional details and additional schedules, including the information for owners' compensation, on the worksheets in the cost report file. Separate worksheets have been included after page 23 for the recording of this type of detail. Additionally, you may also insert these sheets in the file behind the pages to which they correspond. Please do not change or delete the sheet names of pages 1 through 23, ReadMe or Macro. Also, do not change any range names or range references.

Page 12 and Pages 12A through 12I

Pages 12A through 12I have been set up to carry forward the totals from the previous page 12. For example, if you use pages 12 through 12F, the total on page 12F will be your grand total building and improvements cost. Only the pages that you use will be printed when the "Print Entire Report" macro is selected.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information. Print macros have been written that will print each individual page or the entire report.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image. After printing the cost report, please review the copy for accuracy and completeness before mailing it to the Bureau of Health Finance. As part of the filing requirements, send the completed Excel file at the same time you send your paper copy. Also, please make sure both the completed file and the paper copy agree prior to sending them to our office.

Cost Report File and Extra Pages

The entire cost report is in one file named Report05.xls. In an Excel file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the file, please call Randy Hulskotter at (217) 782-1630. You may also contact our office by email at the address located in the footer of this memo



Shortcut=
Hold down
Control Key and press m



Shortcut=
Hold down
Control Key and press q

To Stop Macro:
Hold down
Control Key and press "Break"

IF YOU WOULD LIKE THE NOTE, " SEE
ACCOUNTANTS' COMPILATION REPORT"
AT THE BOTTOM OF EVERY PAGE, ENTER
THE NUMBER 1 IN CELL E4.

1

If you would like Pages Summary A and Summary B
to print, change cell E11 to zero.

0

Facility Name & ID Number Arlington Rehab & Living Center# 0040899 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 12/16/2005

	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	<u>180</u>	Skilled (SNF)	<u>184</u>	<u>65,764</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>184</u>	<u>65,764</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,105</u>	<u>6,642</u>	<u>10,962</u>	<u>38,709</u>	8
9	SNF/PED					9
10	ICF	<u>22,359</u>	<u>1,908</u>	<u>263</u>	<u>24,530</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,464</u>	<u>8,550</u>	<u>11,225</u>	<u>63,239</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.16%

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)

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/02/1996

J. Was the facility purchased or leased after January 1, 1978?

YES Date 01/02/1996 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 184 and days of care provided 9,060Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	318,395	86,733	8,160	413,288		413,288		413,288		1
2	Food Purchase		338,291		338,291	(24,090)	314,201	(456)	313,745		2
3	Housekeeping	269,809	36,482		306,291		306,291		306,291		3
4	Laundry	16,709	14,756	1,284	32,749		32,749		32,749		4
5	Heat and Other Utilities			167,851	167,851		167,851		167,851		5
6	Maintenance	45,415	32,187	100,800	178,402		178,402		178,402		6
7	Other (specify):*										7
8	TOTAL General Services	650,328	508,449	278,095	1,436,872	(24,090)	1,412,782	(456)	1,412,326		8
	B. Health Care and Programs										
9	Medical Director			31,000	31,000		31,000		31,000		9
10	Nursing and Medical Records	3,035,055	167,237	155,691	3,357,983		3,357,983	(69)	3,357,914		10
10a	Therapy	115,193	1,394	1,701	118,288		118,288	(308)	117,980		10a
11	Activities	142,606	10,409	7,861	160,876		160,876	(186)	160,690		11
12	Social Services	149,923		9,571	159,494		159,494		159,494		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,442,777	179,040	205,824	3,827,641		3,827,641	(563)	3,827,078		16
	C. General Administration										
17	Administrative	137,843		100,000	237,843		237,843		237,843		17
18	Directors Fees										18
19	Professional Services			139,670	139,670	(13,056)	126,614	(3,761)	122,853		19
20	Dues, Fees, Subscriptions & Promotions			75,306	75,306		75,306	(30,150)	45,156		20
21	Clerical & General Office Expenses	174,787	17,354	309,860	502,001		502,001	(197,334)	304,667		21
22	Employee Benefits & Payroll Taxes			614,466	614,466	24,090	638,556	(210)	638,346		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,166	9,166		9,166		9,166		24
25	Other Admin. Staff Transportation			8,913	8,913		8,913		8,913		25
26	Insurance-Prop.Liab.Malpractice			116,937	116,937		116,937		116,937		26
27	Other (specify):*										27
28	TOTAL General Administration	312,630	17,354	1,374,318	1,704,302	11,034	1,715,336	(231,456)	1,483,881		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,405,735	704,843	1,858,237	6,968,815	(13,056)	6,955,759	(232,474)	6,723,285		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

#0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			52,200	52,200		52,200	232,442	284,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			172,634	172,634		172,634	6,929	179,563			32
33	Real Estate Taxes			119,705	119,705	13,056	132,761	(8,812)	123,949			33
34	Rent-Facility & Grounds			923,736	923,736		923,736	(923,736)				34
35	Rent-Equipment & Vehicles			31,667	31,667		31,667	(3,854)	27,813			35
36	Other (specify):*											36
37	TOTAL Ownership			1,299,942	1,299,942	13,056	1,312,998	(697,031)	615,967			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		375,047	799,100	1,174,147		1,174,147	(118,588)	1,055,559			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,646	98,646		98,646		98,646			42
43	Other (specify):*	84,452			84,452		84,452	(84,452)	0			43
44	TOTAL Special Cost Centers	84,452	375,047	897,746	1,357,245		1,357,245	(203,040)	1,154,205			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,490,187	1,079,890	4,055,925	9,626,002		9,626,002	(1,132,545)	8,493,457			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	216,968	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(456)	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	(3,688)	21		18
19	Entertainment	(10,257)	21		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	(173,501)	21		24
25	Fund Raising, Advertising and Promotional	(24,700)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,094)	20		28
29	Other-Attach Schedule	(154,469)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,197)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(979,348)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (979,348)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,132,545)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49	50	51	52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Marketing Wages	84,482
2	Bank Charges	7,871
3	Franchise Tax	(2,851)
4	Building Company-Professional Fees	(1,500)
5	Building Company-Management Fees	(27,440)
6	Building Company-Franchise Fees	(250)
7	Building Company-Trust Fees	(270)
8	Building Company-State Taxes	(11,412)
9	Recovery of Theft Loss	(186)
10	Jury Duty	(69)
11	PPA-Payroll Taxes	(210)
12	Auto Lease- Marketing	(3,854)
13	CPPE Dues	(2,358)
14	Marketing Bonus	(400)
15	B-E Tax Refund 2004	(8,812)
16	Legal Retainer Fees	(3,000)
17	Legal Expense	(764)
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101	Total	(154,468)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arlington Rehab & Living Center# 0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05**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													1
2	Food Purchase	(456)											(456)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	TOTAL General Services	(456)											(456)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(69)											(69)	10
10a	Therapy			(308)									(308)	10a
11	Activities	(186)											(186)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(255)		(308)									(563)	16
	C. General Administration													
17	Administrative	(27,440)	27,440											17
18	Directors Fees													18
19	Professional Services	(5,270)	1,509										(3,761)	19
20	Fees, Subscriptions & Promotions	(30,670)	520										(30,150)	20
21	Clerical & General Office Expenses	(208,746)	11,412										(197,334)	21
22	Employee Benefits & Payroll Taxes	(210)											(210)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(272,337)	40,881										(231,456)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(273,047)	40,881	(308)									(232,474)	29

STATE OF ILLINOIS

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	216,968	15,474										232,442	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		6,929										6,929	32
33	Real Estate Taxes	(8,812)											(8,812)	33
34	Rent-Facility & Grounds		(923,736)										(923,736)	34
35	Rent-Equipment & Vehicles	(3,854)											(3,854)	35
36	Other (specify):*													36
37	TOTAL Ownership	204,302	(901,333)										(697,031)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(118,588)									(118,588)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(84,452)											(84,452)	43
44	TOTAL Special Cost Centers	(84,452)		(118,588)									(203,040)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(153,197)	(860,452)	(118,896)									(1,132,545)	45

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		Aurora Rehabilitation and Living Center	Aurora, IL	Kedzie Home, LLC	Chicago, IL	Building Co.
				Simply Rehab	Skokie, IL	Therapy

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 923,736	Kedzie Home, LLC	100.00%	\$	\$ (923,736)	1
2	V	32 Interest	132	Kedzie Home, LLC	100.00%		(132)	2
3	V	30 Depreciation		Kedzie Home, LLC	100.00%	15,474	15,474	3
4	V	19 Professional Fees		Kedzie Home, LLC	100.00%	1,509	1,509	4
5	V	17 Management Fees		Kedzie Home, LLC	100.00%	27,440	27,440	5
6	V	20 Franchise Fees		Kedzie Home, LLC	100.00%	250	250	6
7	V	20 Trust Fees		Kedzie Home, LLC	100.00%	270	270	7
8	V	21 State Income Tax		Kedzie Home, LLC	100.00%	11,412	11,412	8
9	V	32 Interest Expense		Kedzie Home, LLC	100.00%	7,061	7,061	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 923,868			\$ 63,416	\$ * (860,452)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary Rehab	\$ 655,013	Simply Rehab	100.00%	\$ 536,425	\$ (118,588)	15
16	V	10a Rehab Consulting	1,700	Simply Rehab	100.00%	1,392	(308)	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		\$ 656,713			\$ 537,817	\$ * (118,896)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Mann	Owner	Administrative	10.00%	See Attached	6.60	15.00%	Allocated	\$ 52,000	17-1	1
2	Patrick Finn	Owner	Administrative	4.00%	See Attached	6.60	15.00%	Allocated	61,486	17-1,17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 113,486		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Simply Rehab
 Street Address 801 Skokie Blvd., Suite 108
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847)562-0800
 Fax Number (847)562-0070

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Rehab	Direct Allocation					536,425	1
2	10a	Ancillary Rehab	Direct Allocation					1,392	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				\$	\$		\$ 537,817	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5	See Supplemental Schedule											
	Working Capital											
6	CIB Bank		X	Line of Credit				375,907			33,005	6
7	Shareholder Loans	X		Working Capital				2,847,431			115,964	7
8	See Supplemental Schedule											
9	TOTAL Facility Related											
	B. Non-Facility Related*											
10	Interest Income/Bldg. Co.	X									(132)	10
11												11
12												12
13	See Supplemental Schedule											
14	TOTAL Non-Facility Related											
15	TOTALS (line 9+line14)											
							\$	\$ 3,934,910			\$ 179,563	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Venture Fund		X	Working Capital			\$	\$ 711,573			\$ 23,665	8							
9	Kedzie Home, LLC	X		Working Capital							7,061	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.)

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 148,069	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.)		\$ 126,323	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (21,746)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 132,639	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.)		\$ 13,056	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 \$ 22,918 For 2004 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.		\$ 123,948	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	102,470	8
	2001	106,831	9
	2002	123,605	10
	2003	132,625	11
	2004	126,323	12
RE TAX ACCRUAL - 126,323*1.05=132,639			
2004 Tax Assessment Refund			

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arlington Rehab & Living Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0040899

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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-31-201-082</u>	<u>Long Term Care Property</u>	\$ <u>121,027.81</u>	\$ <u>121,027.81</u>
2. <u>15-31-201-083</u>	<u>Long Term Care Property</u>	\$ <u>5,294.76</u>	\$ <u>5,294.76</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>126,322.57</u>	\$ <u>126,322.57</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arlington Rehab & Living Center COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0040899

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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,302 B. General Construction Type: Exterior Cinder Block Frame Drivit/Face Brick Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>132,000</u>	<u>1995</u>	<u>\$ 172,192</u>	1
2					2
3	TOTALS	132,000		\$ 172,192	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1996	31,575		20	1,644	1,644	15,808	9
10	Various			1997	34,251		20	1,712	1,712	12,390	10
11	Various			1998	115,118		20	5,755	5,755	42,291	11
12	Various			1999	8,794		20	439	439	2,431	12
13	Various			2000	5,943		20	553	553	3,215	13
14	Various			2001	11,296		20	566	566	2,569	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		5,634,743	15,474		161,423	145,949	802,091	67
68								68
69			52,200			(52,200)		69
70		\$ 5,841,720	\$ 67,674		\$ 172,092	\$ 104,418	\$ 880,795	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center# 0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,841,720	\$ 67,674		\$ 172,092	\$ 104,418	\$ 880,795	1
2	Exp.Tank-Ldry Boiler	2002	2,390		20	239	239	837	2
3	Prus Design-Nurse Station	2002	13,984		20	1,398	1,398	4,312	3
4	Fire Sprinkler Work	2002	4,689		20	469	469	1,485	4
5	Boiler & A/C Replacement	2002	16,080		20	1,608	1,608	5,762	5
6	Boiler Repairs	2002	2,347		20	235	235	763	6
7	Cozza-Carpeting	2002	2,178		20	218	218	871	7
8	Furnish And Install Resilient Tile	2003	5,807		20	581	581	1,403	8
9	Carpet	2003	1,190		20	119	119	278	9
10	Data & Phone Cableing	2003	741		20	74	74	173	10
11	Install Electric Service	2003	1,020		20	102	102	230	11
12	Install Lamps & Ballast	2003	960		20	96	96	216	12
13	Install Data Cable Lines	2003	1,215		20	121	121	253	13
14	Repair Dining Room Fan Coil	2003	767		20	77	77	160	14
15	Hvac Repairs	2003	940		20	94	94	196	15
16	Generator Repairs	2004	1,437		20	144	144	287	16
17	Wallpaper 100 Unit Dining Room	2004	1,650		20	165	165	316	17
18	Wallpaper Supplies	2004	271		20	27	27	52	18
19	24 Call Cord Assemblys	2004	831		20	83	83	159	19
20	6 Call Cord Assemblys, 12 Hand Showers	2004	392		20	39	39	75	20
21	Paint Base Cove Casing Plugs	2004	632		20	63	63	121	21
22	Loadbank Of Generator	2004	1,019		20	102	102	204	22
23	Flooring, Ceiling, Electrical, Plumbing Work	2004	15,671		20	1,567	1,567	2,612	23
24	Thermopane Glass	2004	712		20	71	71	125	24
25	Water Storage Tank	2004	17,000		20	1,700	1,700	2,692	25
26	Disposer Sink Mounted 208 Volts	2004	2,033		20	203	203	305	26
27	Repl Condenser Fan & Motor	2004	1,002		20	100	100	150	27
28	Emergency Service For 2 Failed Pump Sys	2004	57,849		20	5,785	5,785	8,195	28
29	2 Electronic Closers	2004	1,070		20	107	107	134	29
30	10 6 Hp Motors	2004	710		20	71	71	89	30
31	Electrical Work	2004	633		20	63	63	69	31
32	New Phone System Setup	2005	765		20	16	16	16	32
33	New Phone System Setup	2005	1,125		20	23	23	23	33
34	TOTAL (lines 1 thru 33)		\$ 6,000,830	\$ 67,674		\$ 187,852	\$ 120,178	\$ 913,358	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center# 0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,000,830	\$ 67,674		\$ 187,852	\$ 120,178	\$ 913,358	1
2	New Phone System Setup	2005	841		20	18	18	18	2
3	New Phone System Setup	2005	275		20	6	6	6	3
4	Walk-In Freezer Door	2005	1,350		20	6	6	6	4
5	Duct Work For Dishwasher	2005	3,406		20	170	170	170	5
6	Drapes & Blinds	2005	23,871		20	1,094	1,094	1,094	6
7	Kitchen Construction	2005	307		20	14	14	14	7
8	Kitchen Construction	2005	1,599		20	73	73	73	8
9	Hallway Remodel	2005	748		20	34	34	34	9
10	Floor Drain Pipes Installation	2005	5,000		20	229	229	229	10
11	Disassemble Existing Plumbing	2005	18,465		20	846	846	846	11
12	Kitchen Construction	2005	403		20	17	17	17	12
13	Kitchen Construction	2005	2,192		20	91	91	91	13
14	Kitchen Construction	2005	120		20	5	5	5	14
15	Kitchen Construction	2005	178		20	7	7	7	15
16	Townsquare Board	2005	1,586		20	59	59	59	16
17	Well Leak Repair	2005	1,063		20	40	40	40	17
18	Boiler Coil Replacement	2005	3,279		20	109	109	109	18
19	Supplies For Wallpaper	2005	227		20	7	7	7	19
20	Supplies For Flooring Project	2005	831		20	24	24	24	20
21	Hvac Motors	2005	550		20	14	14	14	21
22	Shower Materials	2005	1,049		20	22	22	22	22
23	Carpet	2005	1,750		20	36	36	36	23
24	Water Filtration	2005	5,800		20	97	97	97	24
25	Chiller Repairs	2005	4,044		20	67	67	67	25
26	Chiller Repairs	2005	735		20	21	21	21	26
27	Chiller Repairs	2005	1,614		20	34	34	34	27
28	Removal Of Damaged Panic Bar Hardware	2005	2,014		20	25	25	25	28
29	Bypass & Chloring Meter Installation	2005	3,476		20	43	43	43	29
30	Mobile Intermediate Hydrocollator Tank	2005	1,197		20	15	15	15	30
31	Chiller Repairs	2005	800		20	10	10	10	31
32	Aggrecko	2005	8,812		20	110	110	110	32
33	Chiller Repairs	2005	621		20	8	8	8	33
34	TOTAL (lines 1 thru 33)		\$ 6,099,033	\$ 67,674		\$ 191,203	\$ 123,529	\$ 916,709	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center# 0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,099,033	\$ 67,674		\$ 191,203	\$ 123,529	\$ 916,709	1
2	Materials & Supplies For Therapy Gym Renovations	2005	937		20	12	12	12	2
3	Flowmeter & Metering Pump	2005	2,228		20	28	28	28	3
4	Colonial Grids	2005	1,000		20	4	4	4	4
5	End Caps & Hand Rails	2005	10,247		20	43	43	43	5
6	Fire Alarm Panel Repairs	2005	853		20	4	4	4	6
7	55 Gallon Tank & Saddle Clamp	2005	1,818		20	8	8	8	7
8	Fire Alarm Panel Repairs	2005	1,406		20	6	6	6	8
9	Wallpaper	2005	1,484		20	56	56	56	9
10	Valances	2005	22,535		20	939	939	939	10
11	Wallpaper	2005	767		20	26	26	26	11
12	Room Signs	2005	2,216		20	92	92	92	12
13	Carpet	2005	6,011		20	175	175	175	13
14	Permit Application Fee	2005			20				14
15	Valances	2005	10,904		20	273	273	273	15
16	Blinds & Wallpaper	2005	1,091		20	27	27	27	16
17	Carpet	2005	3,011		20	88	88	88	17
18	Carpet	2005	1,060		20	22	22	22	18
19	Framing & Drywall	2005	38,500		20	481	481	481	19
20	Electrical Work	2005	2,171		20	18	18	18	20
21	Flooring	2005	480		20	4	4	4	21
22	Window Treatment Installation	2005	627		20	3	3	3	22
23	Repair Flooring	2005	788		20	3	3	3	23
24	Computer & Telephone Cableing	2005	1,170		20	5	5	5	24
25	Exhaust Fans, Ductwork	2005	1,175		20	5	5	5	25
26	Electrical Work	2005	3,307		20	28	28	28	26
27	Recessed Pendants	2005	3,480		20	44	44	44	27
28	Plumbing & Ceramic Tile	2005	2,026		20	25	25	25	28
29	Carpet	2005	252		20	3	3	3	29
30	Counter Top	2005	394		20	5	5	5	30
31	Framing & Drywall	2005	19,067		20	159	159	159	31
32	Wallpaper	2005	30		20				32
33	2 A/C Units	2005	1,161		20	24	24	24	33
34	TOTAL (lines 1 thru 33)		\$ 6,241,229	\$ 67,674		\$ 193,813	\$ 126,139	\$ 919,319	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center# 0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,241,229	\$ 67,674		\$ 193,813	\$ 126,139	\$ 919,319	1
2	Drywall & Supplies	2005	1,925		20	40	40	40	2
3	Door	2005	111		20				3
4	Ductwork & Sheet Metal	2005	4,010		20	50	50	50	4
5	Bathroom & Resident Room Renovations	2005	19,800		20	248	248	248	5
6	Supplies For Carpet & Floor Prep	2005	3,489		20	29	29	29	6
7	Handrails	2005	541		20	9	9	9	7
8	Kewanee Copr - Improvement	2005	1,050		20	13	13	13	8
9	Door & Hardware	2005	3,898		20	81	81	81	9
10	Doors	2005	2,985		20	62	62	62	10
11	Demolition, Framing, Drywall	2005	25,850		20	431	431	431	11
12	Carpet	2005	3,485		20	44	44	44	12
13	Wall Cutting & Reblocking For New Corridor	2005	4,500		20	56	56	56	13
14	Floor & Wall Tile	2005	2,500		20	42	42	42	14
15	Carpet, Vinyl Base & Floor Prep	2005	445		20	6	6	6	15
16	Carpet, Vinyl Base & Floor Prep	2005	361		20	5	5	5	16
17	Wallpaper	2005	228		20	3	3	3	17
18	Electrical Work	2005	3,430		20	57	57	57	18
19	Electrical Work	2005	1,596		20	20	20	20	19
20	Door Light	2005	79		20	1	1	1	20
21	Window & Door Wire Glass	2005	100		20	1	1	1	21
22	Door Wire Glass	2005	551		20	7	7	7	22
23	Electrical Materials	2005	20		20				23
24	Sprinkler Plan Copies	2005			20				24
25	Wallpaper Supplies	2005	476		20	20	20	20	25
26	Vinyl Flooring	2005	6,034		20	251	251	251	26
27	Wallpaper & Handrails	2005	4,320		20	180	180	180	27
28	Vinyl Flooring & Wallpaper	2005	4,552		20	190	190	190	28
29	Flooring Replacement	2005	5,600		20	210	210	210	29
30	Vinyl Flooring & Wallpaper	2005	7,729		20	290	290	290	30
31	Flooring Replacement	2005	4,930		20	185	185	185	31
32	Wall Replacement	2005	4,000		20	133	133	133	32
33	Wallpapering	2005	3,050		20	102	102	102	33
34	TOTAL (lines 1 thru 33)		\$ 6,362,874	\$ 67,674		\$ 196,579	\$ 128,905	\$ 922,085	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,362,874	\$ 67,674		\$ 196,579	\$ 128,905	\$ 922,085	1
2	Vinyl Flooring & Wallpaper	2005	7,366		20	215	215	215	2
3	Installation Of Wall Coverings	2005	2,800		20	82	82	82	3
4	Flooring Replacement	2005	4,000		20	133	133	133	4
5	Vinyl Flooring & Wallpaper	2005	2,003		20	50	50	50	5
6	Flooring Replacement	2005	2,400		20	60	60	60	6
7	Wall Covering	2005	3,600		20	90	90	90	7
8	Wall Covering	2005	1,200		20	30	30	30	8
9	Flooring Replacement	2005	5,831		20	121	121	121	9
10	Data & Telephone Cableing, Smoke Detectors	2005	1,897		20	24	24	24	10
11	Relocate Fire Alarm Strobes & Pull Stations	2005	325		20	4	4	4	11
12	Flooring	2005	4,538		20	57	57	57	12
13	Flooring	2005	780		20	10	10	10	13
14	Wallpaper & Blinds	2005	4,826		20	60	60	60	14
15	Locking Sliding Glass Window	2005	942		20	12	12	12	15
16	Wallpaper	2005	14,173		20	709	709	709	16
17	Wallpaper	2005	1,442		20	72	72	72	17
18	Supplies For Remodeling Project	2005	1,937		20	8	8	8	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)		\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822		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)	\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822		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)	\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822	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)	\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822	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)		\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822	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)	\$ 6,422,934	\$ 67,674		\$ 198,316	\$ 130,642	\$ 923,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1996	\$ 20,105	\$		\$ 1,005	\$ 1,005	\$	4
5				1995	5,614,638	15,474		160,418	144,944	802,091	5
6											6
7											7
8											8
	Improvement Type**										
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		5,634,743	15,474		161,423	145,949	802,091	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 610,601	\$	\$ 72,140	\$ 72,140	10	\$ 482,761	71
72	Current Year Purchases	68,758		2,637	2,637	10	2,637	72
73	Fully Depreciated Assets	40,152				10	40,152	73
74								74
75	TOTALS	\$ 719,511	\$	\$ 74,777	\$ 74,777		\$ 525,550	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FORD BUS-91	1996	\$ 24,698	\$	\$ 2,470	\$ 2,470	5	\$ 22,847	76
77		BUS	1999	66,022		6,602	6,602	5	42,914	77
78		98 FORD F250 PICKUP	2001	5,371				5	17,223	78
79		See Attached Schedule	2002	13,598		2,477	2,477	5	8,640	79
80	TOTALS			\$ 109,689	\$	\$ 11,549	\$ 11,549		\$ 91,624	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)	\$ 7,424,326	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,674	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 284,642	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 216,968	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,540,996	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 23,068 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>2003 Car Lease</u>	\$ _____	\$ <u>8,599</u>	17
18	<u>Personal Portion</u>			<u>(3,854)</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>4,745</u>	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 299,756	\$		\$ 299,756	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			58,164			58,164	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			298,924			298,924	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				341,271		341,271	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					142,256	33,776		176,032	13
14	TOTAL			\$		\$ 799,100	\$ 375,047		\$ 1,174,147	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ 60,213	\$ 178,357	1
2	Cash-Patient Deposits	250	250	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,087,367	2,087,367	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,144	71,144	6
7	Other Prepaid Expenses	4,374	4,374	7
8	Accounts Receivable (owners or related parties)	150,263	150,263	8
9	Other(specify): <u>See Attached Schedule</u>	9,864	9,864	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,383,475	\$ 2,501,619	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		94,987	13
14	Buildings, at Historical Cost		425,525	14
15	Leasehold Improvements, at Historical Cost	762,179	762,179	15
16	Equipment, at Historical Cost	791,361	791,361	16
17	Accumulated Depreciation (book methods)	(761,349)	(915,441)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	(4,825)	(4,825)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 787,366	\$ 1,153,786	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,170,841	\$ 3,655,405	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 960,172	\$ 960,172	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	93	93	28
29	Short-Term Notes Payable	3,559,003	3,559,003	29
30	Accrued Salaries Payable	86,518	86,518	30
31	Accrued Taxes Payable (excluding real estate taxes)	56,444	56,444	31
32	Accrued Real Estate Taxes(Sch.IX-B)	132,639	132,639	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	200,397	200,397	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,995,266	\$ 4,995,266	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	375,907	375,907	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 375,907	\$ 375,907	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,371,173	\$ 5,371,173	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,200,332)	\$ (1,715,768)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,170,841	\$ 3,655,405	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 518,873	1
2	Restatements (describe):		2
3	<u>See Attached</u>	(2,976,202)	3
4	<u>Unreconciled Difference</u>	(3,488)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,460,817)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	310,485	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	(50,000)	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)	\$ 260,485	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)	\$ (2,200,332)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/05Ending: 12/31/05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,071,113	1
2	Discounts and Allowances for all Levels	91,053	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,162,166	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,272,846	6
7	Oxygen	32,672	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,305,518	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	325,692	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,357	19
20	Radiology and X-Ray		20
21	Other Medical Services	107,838	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 443,887	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	24,916	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,916	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,936,487	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,436,872	31
32	Health Care	3,827,641	32
33	General Administration	1,704,302	33
B. Capital Expense			
34	Ownership	1,299,942	34
C. Ancillary Expense			
35	Special Cost Centers	1,258,599	35
36	Provider Participation Fee	98,646	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,626,002	40
41	Income before Income Taxes (line 30 minus line 40)**	310,485	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 310,485	43

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

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

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

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/05

Ending:

12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,761	1,929	\$ 80,283	\$ 41.62	1
2	Assistant Director of Nursing	1,581	1,758	56,596	32.19	2
3	Registered Nurses	29,965	31,113	982,880	31.59	3
4	Licensed Practical Nurses	18,628	19,069	560,074	29.37	4
5	CNAs & Orderlies	96,745	102,350	1,319,773	12.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,147	7,781	115,193	14.80	8
9	Activity Director	2,025	2,086	35,852	17.19	9
10	Activity Assistants	9,790	10,351	106,754	10.31	10
11	Social Service Workers	9,206	9,206	149,923	16.29	11
12	Dietician	1,897	2,125	51,588	24.28	12
13	Food Service Supervisor					13
14	Head Cook	4,854	5,362	72,817	13.58	14
15	Cook Helpers/Assistants	23,210	24,426	193,990	7.94	15
16	Dishwashers					16
17	Maintenance Workers	2,761	3,183	45,415	14.27	17
18	Housekeepers	31,201	33,029	269,809	8.17	18
19	Laundry	2,324	2,408	16,709	6.94	19
20	Administrator	1,993	2,131	137,843	64.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,582	6,582	174,787	26.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,905	2,086	35,449	16.99	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,800	2,800	84,452	30.16	33
34	TOTAL (lines 1 - 33)	256,375	269,775	\$ 4,490,187 *	\$ 16.64	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	192	\$ 8,160	01-03	35
36	Medical Director	Monthly	31,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	719	30,794	10-03	38
39	Pharmacist Consultant	Monthly	2,418	10-03	39
40	Physical Therapy Consultant	17	855	10a-03	40
41	Occupational Therapy Consultant	1	14	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	17	832	10a-03	43
44	Activity Consultant	153	7,861	11-03	44
45	Social Service Consultant	179	9,421	12-03	45
46	Other(specify)				46
47					47
48	<u>Social Service Consultant</u>	3	150	12-03	48
49	TOTAL (lines 35 - 48)	1,279	\$ 91,505		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,919	\$ 92,371	10-03	50
51	Licensed Practical Nurses	756	30,108	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,675	\$ 122,479		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/05

Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gregory Kennedy	Administrator	0	\$ 93,083	Workers' Compensation Insurance	\$ 117,149	IDPH License Fee	\$	
Gregory Seeger	Administrator	0	44,760	Unemployment Compensation Insurance	35,417	Advertising: Employee Recruitment	27,200	
				FICA Taxes	336,742	Health Care Worker Background Check		
				Employee Health Insurance	91,019	(Indicate # of checks performed <u>91</u>)	1,464	
				Employee Meals	24,090	Advertising & Promotion	24,701	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	9,257	
				401K Matching	1,813	License & Fees	7,236	
				Other Employee Benefits	32,117	Yellow Page Advertising	3,094	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 137,843					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Patrick Finn			\$ 48,000				Out-of-State Travel	\$
James Mann			52,000				In-State Travel	
							Seminar Expense	9,166
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 100,000	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				\$ 638,346			\$ 45,156	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 14,466					
Camille Koehl & Associates	Accounting		188					
Personnel Planners	Unemployment Consult		300					
Talx Corp	Unemployment Consult		1,163					
See Attached	Legal		97,308					
Health Data Systems	Computer Services		4,626					
American Data	Computer Services		3,323					
Computerized Business Solutions	Computer Services		6,017					
CDW	Computer Services		2,229					
Terry Bathum	Computer Services		1,806					
Christopher Burke Engineering	Engineering Consultant		3,191					
See Supplemental Schedule			5,054					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 139,670	\$			\$ 9,166	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Arlington Rehab & Living Center

Report Period Beginning: 01/01/05 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 - \$9,952.20
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,453 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. \$ 98,646
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? _____ 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. \$ 24,090 Has any meal income been offset against related costs? No 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% In 14
d. Have vehicle usage logs been maintained? Yes
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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT