

Facility Name & ID Number Arlington Rehab & Living Center

0040899 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 12/26/06

	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>184</u>	Skilled (SNF)	<u>190</u>	<u>67,196</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>184</u>	TOTALS	<u>190</u>	<u>67,196</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>31,945</u>	<u>5,805</u>	<u>12,747</u>	<u>50,497</u>	8
9	SNF/PED					9
10	ICF	<u>11,293</u>	<u>1,557</u>	<u>1,400</u>	<u>14,250</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,238</u>	<u>7,362</u>	<u>14,147</u>	<u>64,747</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.36%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

YES NO

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 1/2/1996

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

YES Date 1/2/1996 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 10,529

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	336,323	73,193	8,602	418,118		418,118		418,118			1
2	Food Purchase		326,524		326,524	(22,776)	303,748	(370)	303,378			2
3	Housekeeping	301,654	31,582		333,236		333,236		333,236			3
4	Laundry	16,297	22,711	2,711	41,719		41,719		41,719			4
5	Heat and Other Utilities			149,138	149,138		149,138		149,138			5
6	Maintenance	40,429	46,239	157,765	244,433		244,433		244,433			6
7	Other (specify):*											7
8	TOTAL General Services	694,703	500,249	318,216	1,513,168	(22,776)	1,490,392	(370)	1,490,022			8
	B. Health Care and Programs											
9	Medical Director			23,500	23,500		23,500		23,500			9
10	Nursing and Medical Records	2,895,068	155,114	63,532	3,113,714		3,113,714	(5,006)	3,108,708			10
10a	Therapy	100,163	4,067	1,121	105,351		105,351		105,351			10a
11	Activities	147,928	6,317	5,852	160,097		160,097		160,097			11
12	Social Services	121,938		7,318	129,256		129,256		129,256			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,265,097	165,498	101,323	3,531,918		3,531,918	(5,006)	3,526,912			16
	C. General Administration											
17	Administrative	130,419		120,466	250,885		250,885		250,885			17
18	Directors Fees											18
19	Professional Services			116,681	116,681		116,681	(5,001)	111,680			19
20	Dues, Fees, Subscriptions & Promotions			93,876	93,876		93,876	(38,442)	55,434			20
21	Clerical & General Office Expenses	245,807	10,815	496,796	753,418		753,418	(400,993)	352,425			21
22	Employee Benefits & Payroll Taxes			631,626	631,626	22,776	654,402	(5,895)	648,507			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,531	5,531		5,531	(195)	5,336			24
25	Other Admin. Staff Transportation			13,043	13,043		13,043		13,043			25
26	Insurance-Prop.Liab.Malpractice			119,360	119,360		119,360	(2,252)	117,108			26
27	Other (specify):*											27
28	TOTAL General Administration	376,226	10,815	1,597,379	1,984,420	22,776	2,007,196	(452,778)	1,554,418			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,336,026	676,562	2,016,918	7,029,506		7,029,506	(458,154)	6,571,352			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:

01/01/06

Ending:

12/31/06

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			147,256	147,256		147,256	127,919	275,175			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			209,662	209,662		209,662	(138)	209,524			32
33	Real Estate Taxes			84,037	84,037		84,037		84,037			33
34	Rent-Facility & Grounds			942,211	942,211		942,211	(942,211)				34
35	Rent-Equipment & Vehicles			19,901	19,901		19,901	(5,380)	14,521			35
36	Other (specify):*											36
37	TOTAL Ownership			1,403,067	1,403,067		1,403,067	(819,810)	583,257			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		354,631	1,294,553	1,649,184		1,649,184	(182,517)	1,466,667			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			100,794	100,794		100,794		100,794			42
43	Other (specify):*	91,233			91,233		91,233	(91,233)				43
44	TOTAL Special Cost Centers	91,233	354,631	1,395,347	1,841,211		1,841,211	(273,750)	1,567,461			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,427,259	1,031,193	4,815,332	10,273,784		10,273,784	(1,551,714)	8,722,070			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: 01/01/06

Ending: 12/31/06

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	97,960	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(370)	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	(28,086)	21		18
19	Entertainment	(13,819)	21		19
20	Contributions	(3,050)	20		20
21	Owner or Key-Man Insurance	(5,694)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(355,607)	21		24
25	Fund Raising, Advertising and Promotional	(30,457)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,333)	20		28
29	Other-Attach Schedule	(163,296)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (504,757)		\$	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)	(1,046,957)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,046,957)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,551,714)		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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Arlington Rehab & Living Center

OW 0040899

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES

	Amount	Reference
1 Marketing Salary	\$ (90,633)	43 1
2 Franchise Tax	(2,851)	21 2
3 Collection Fees	(6,30)	21 3
4 ICLTC Cage Diets	(2,602)	20 4
5 PPA-Payroll Tax	2814	22 5
6 PPA-Insurance	(2,252)	26 6
7 Non-Allowable Auto Lease	(5,300)	38 7
8 Patient Meals	(5,400)	19 8
9 Non-Allowable Seminar	(195)	24 9
10 Non-Allowable Legal	(5,001)	19 10
11 Marketing bonus	(600)	43 11
12 Building Company-Professional Fees	(605)	19 12
13 Building Company-Management Fees	(35,056)	17 13
14 Building Company-Franchise Fees	(250)	20 14
15 Building Company-Trust Fees	(540)	20 15
16 Building Company-State Taxes	(11,444)	21 16
17 Building Company - Misc Expense	(50)	21 17
18		18
19		19
20		20
21		21
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43
44		44
45		45
46		46
47		47
48		48
49		49
50		50
51		51
52		52
53		53
54		54
55		55
56		56
57		57
58		58
59		59
60		60
61		61
62		62
63		63
64		64
65		65
66		66
67		67
68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90		90
91		91
92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(163,296)	101

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/06

Ending:

12/31/06**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	(370)											(370)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	TOTAL General Services	(370)											(370)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,006)											(5,006)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(5,006)											(5,006)	16
	C. General Administration													
17	Administrative	(35,056)	35,056											17
18	Directors Fees													18
19	Professional Services	(5,606)	605										(5,001)	19
20	Fees, Subscriptions & Promotions	(39,232)	790										(38,442)	20
21	Clerical & General Office Expenses	(412,487)	11,494										(400,993)	21
22	Employee Benefits & Payroll Taxes	(5,895)											(5,895)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(195)											(195)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(2,252)											(2,252)	26
27	Other (specify):*													27
28	TOTAL General Administration	(500,723)	47,945										(452,778)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(506,099)	47,945										(458,154)	29

STATE OF ILLINOIS

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	97,960	29,959										127,919	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5)	(133)										(138)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(942,211)										(942,211)	34
35	Rent-Equipment & Vehicles	(5,380)											(5,380)	35
36	Other (specify):*													36
37	TOTAL Ownership	92,575	(912,385)										(819,810)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(182,517)									(182,517)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(91,233)											(91,233)	43
44	TOTAL Special Cost Centers	(91,233)		(182,517)									(273,750)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(504,757)	(864,440)	(182,517)									(1,551,714)	45

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	Chicago, IL	Bldg. Co.
				Simply Rehab	Skokie, IL	Therapy Co.

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	\$ 942,211	Kedzie Home, LLC	100.00%	\$	\$ (942,211)	1
2	V	32 Interest	133	Kedzie Home, LLC			(133)	2
3	V	30 Depreciation		Kedzie Home, LLC		29,959	29,959	3
4	V	19 Professional Fees		Kedzie Home, LLC		605	605	4
5	V	17 Management Fees		Kedzie Home, LLC		35,056	35,056	5
6	V	20 Franchise Fees		Kedzie Home, LLC		250	250	6
7	V	20 Trust Fees		Kedzie Home, LLC		540	540	7
8	V	21 State Income Tax		Kedzie Home, LLC		11,444	11,444	8
9	V	21 Misc Expense		Kedzie Home, LLC		50	50	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 942,344			\$ 77,904	\$ * (864,440)	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	1,156,846	Simply Rehab	100.00%	974,329	(182,517)	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			\$ 1,156,846			\$ 974,329	\$ * (182,517)	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: 01/01/06

Ending: 12/31/06

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/06

Ending: 12/31/06

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: 01/01/06

Ending: 12/31/06

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: 01/01/06

Ending: 12/31/06

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/06

Ending: 12/31/06

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: 01/01/06

Ending: 12/31/06

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: 01/01/06 Ending: 12/31/06

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	13.20%	Mgmt Fee	\$ 58,465	17-3	1
2	Patrick Finn	Owner	Administrative	4.00%	See Attached	6.60	13.20%	Mgmt Fee	62,001	17-3	2
3	Aaron Mann	Relative	Administrator	None	None	2.31	5.78%	Salary	9,443	17-1, 20-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 129,909		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:

01/01/06

Ending: 12/31/06

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: 01/01/06

Ending: 12/31/06

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					974,329	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				\$	\$		\$ 974,329	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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				320,844			26,733	6
7	Shareholder Loan	X		Working Capital				2,828,972			114,676	7
8	See Supplemental Schedule											
9	TOTAL Facility Related											
	B. Non-Facility Related*											
10	Interest Income		X								(5)	10
11	Interest Income		X								(133)	11
12												12
13	See Supplemental Schedule											
14	TOTAL Non-Facility Related											
15	TOTALS (line 9+line14)											
							\$	\$			\$	15
								4,169,683			209,524	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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: 01/01/06 Ending: 12/31/06

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			\$	\$ 1,019,867		\$ 68,253	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related									20										

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

** 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 2005 report.		\$ <u>132,639</u>	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.)		\$ <u>105,696</u>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>(26,943)</u>	3																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>110,980</u>	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>281</u> For <u>00-01</u> 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.		\$ <u>84,037</u>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td><u>106,831</u></td><td>8</td></tr> <tr><td>2002</td><td><u>123,605</u></td><td>9</td></tr> <tr><td>2003</td><td><u>132,625</u></td><td>10</td></tr> <tr><td>2004</td><td><u>126,323</u></td><td>11</td></tr> <tr><td>2005</td><td><u>105,696</u></td><td>12</td></tr> </table>	2001	<u>106,831</u>	8	2002	<u>123,605</u>	9	2003	<u>132,625</u>	10	2004	<u>126,323</u>	11	2005	<u>105,696</u>	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	<u>106,831</u>	8																																		
2002	<u>123,605</u>	9																																		
2003	<u>132,625</u>	10																																		
2004	<u>126,323</u>	11																																		
2005	<u>105,696</u>	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
RE Tax Accrual = 105696 x 1.05																																				
Refund not offset because the refund was not used to set a Real Estate tax rate																																				

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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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>Long Term Care Property</u>	<u>15-31-201-083</u>	\$ <u>5,412.06</u>	\$ <u>5,412.06</u>
2. <u>Long Term Care Property</u>	<u>15-31-201-082</u>	\$ <u>100,283.41</u>	\$ <u>100,283.41</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>105,695.47</u>	\$ <u>105,695.47</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/06 Ending:

12/31/06

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:

01/01/06

Ending:

12/31/06

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	1,534	1,534	17,342	9
10	Various			1997	34,251		20	1,712	1,712	14,103	10
11	Various			1998	115,118		20	5,755	5,755	48,047	11
12	Various			1999	8,794		20	439	439	2,873	12
13	Various			2000	5,943		20	553	553	3,768	13
14	Various			2001	11,296		20	566	566	3,136	14
15	Various			2002	41,668		20	4,167	4,167	18,196	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:

01/01/06

Ending:

12/31/06

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	29,959		161,423	131,464	184,050	67
68								68
69			147,256			(147,256)		69
70		\$ 5,883,388	\$ 177,215		\$ 176,149	\$ (1,066)	\$ 291,515	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:

01/01/06

Ending:

12/31/06**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		\$ 5,883,388	\$ 177,215		\$ 176,149	\$ (1,066)	\$ 291,515	1
2	Furnish And Install Resilient Tile	2003	5,807		20	581	581	1,984	2
3	Carpet	2003	1,190		20	119	119	397	3
4	Data & Phone Cableing	2003	741		20	74	74	247	4
5	Install Electric Service	2003	1,020		20	102	102	332	5
6	Install Lamps & Ballast	2003	960		20	96	96	312	6
7	Install Data Cable Lines	2003	1,215		20	121	121	375	7
8	Repair Dining Room Fan Coil	2003	767		20	77	77	236	8
9	Hvac Repairs	2003	940		20	94	94	290	9
10	Generator Repairs	2004	1,437		20	144	144	431	10
11	Wallpaper 100 Unit Dining Room	2004	1,650		20	165	165	481	11
12	Wallpaper Supplies	2004	271		20	27	27	79	12
13	24 Call Cord Assemblys	2004	831		20	83	83	242	13
14	6 Call Cord Assemblys, 12 Hand Showers	2004	392		20	39	39	114	14
15	Paint Base Cove Casing Plugs	2004	632		20	63	63	184	15
16	Loadbank Of Generator	2004	1,019		20	102	102	306	16
17	Flooring, Ceiling, Electrical, Plumbing Work	2004	15,671		20	1,567	1,567	4,179	17
18	Thermopane Glass	2004	712		20	71	71	196	18
19	Water Storage Tank	2004	17,000		20	1,700	1,700	4,392	19
20	Disposer Sink Mounted 208 Volts	2004	2,033		20	203	203	508	20
21	Repl Condenser Fan & Motor	2004	1,002		20	100	100	251	21
22	Emergency Service For 2 Failed Pump Sys	2004	57,849		20	5,785	5,785	13,980	22
23	2 Electronic Closers	2004	1,070		20	107	107	241	23
24	10 6 Hp Motors	2004	710		20	71	71	160	24
25	Electrical Work	2004	633		20	63	63	132	25
26	New Phone System Setup	2005	765		20	38	38	54	26
27	New Phone System Setup	2005	1,125		20	56	56	80	27
28	New Phone System Setup	2005	841		20	42	42	60	28
29	New Phone System Setup	2005	275		20	14	14	19	29
30	Walk-In Freezer Door	2005	1,350		20	68	68	73	30
31	Duct Work For Dishwasher	2005	3,406		20	170	170	341	31
32	Drapes & Blinds	2005	23,871		20	1,194	1,194	2,288	32
33	Kitchen Construction	2005	307		20	15	15	29	33
34	TOTAL (lines 1 thru 33)		\$ 6,030,880	\$ 177,215		\$ 189,300	\$ 12,085	\$ 324,508	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:

01/01/06

Ending:

12/31/06**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		\$ 6,030,880	\$ 177,215		\$ 189,300	\$ 12,085	\$ 324,508	1
2	<u>Kitchen Construction</u>	2005	1,599		20	80	80	153	2
3	<u>Hallway Remodel</u>	2005	748		20	37	37	72	3
4	<u>Floor Drain Pipes Installation</u>	2005	5,000		20	250	250	479	4
5	<u>Disassemble Existing Plumbing</u>	2005	18,465		20	923	923	1,770	5
6	<u>Kitchen Construction</u>	2005	403		20	20	20	37	6
7	<u>Kitchen Construction</u>	2005	2,192		20	110	110	201	7
8	<u>Kitchen Construction</u>	2005	120		20	6	6	11	8
9	<u>Kitchen Construction</u>	2005	178		20	9	9	16	9
10	<u>Townsquare Board</u>	2005	1,586		20	79	79	139	10
11	<u>Well Leak Repair</u>	2005	1,063		20	53	53	93	11
12	<u>Boiler Coil Replacement</u>	2005	3,279		20	164	164	273	12
13	<u>Improvement</u>	2005	227		20	11	11	18	13
14	<u>Improvement</u>	2005	831		20	42	42	66	14
15	<u>Hvac Motors</u>	2005	550		20	28	28	41	15
16	<u>Shower Materials</u>	2005	1,049		20	52	52	74	16
17	<u>Carpet</u>	2005	1,750		20	88	88	124	17
18	<u>Water Filtration</u>	2005	5,800		20	290	290	387	18
19	<u>Chiller Repairs</u>	2005	4,044		20	202	202	270	19
20	<u>Chiller Repairs</u>	2005	735		20	37	37	58	20
21	<u>Chiller Repairs</u>	2005	1,614		20	81	81	114	21
22	<u>Removal Of Damaged Panic Bar Hardware</u>	2005	2,014		20	101	101	126	22
23	<u>Bypass & Chloring Meter Installation</u>	2005	3,476		20	174	174	217	23
24	<u>Mobile Intermediate Hydrocollator Tank</u>	2005	1,197		20	60	60	75	24
25	<u>Chiller Repairs</u>	2005	800		20	40	40	50	25
26	<u>Aggrecko</u>	2005	8,812		20	441	441	551	26
27	<u>Work Order</u>	2005	621		20	31	31	39	27
28	<u>Building Remodeling Project</u>	2005	937		20	47	47	59	28
29	<u>Flowmeter & Metering Pump</u>	2005	2,228		20	111	111	139	29
30	<u>Colonial Grids</u>	2005	1,000		20	50	50	54	30
31	<u>End Caps & Hand Rails</u>	2005	10,247		20	512	512	555	31
32	<u>Fire Alarm Panel Repairs</u>	2005	853		20	43	43	46	32
33	<u>55 Gallon Tank & Saddle Clamp</u>	2005	1,818		20	91	91	98	33
34	TOTAL (lines 1 thru 33)		\$ 6,116,116	\$ 177,215		\$ 193,563	\$ 16,348	\$ 330,913	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:

01/01/06

Ending:

12/31/06**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		\$ 6,116,116	\$ 177,215		\$ 193,563	\$ 16,348	\$ 330,913	1
2	Fire Alarm Panel Repairs	2005	1,406		20	70	70	76	2
3	Wallpaper	2005	1,484		20	74	74	130	3
4	Valances	2005	22,535		20	1,127	1,127	2,066	4
5	Wallpaper	2005	767		20	38	38	64	5
6	Room Signs	2005	2,216		20	111	111	203	6
7	Carpet	2005	6,011		20	301	301	476	7
8	Permit Application Fee	2005			20				8
9	Valances	2005	10,904		20	545	545	818	9
10	Blinds & Wallpaper	2005	1,091		20	55	55	82	10
11	Carpet	2005	3,011		20	151	151	238	11
12	Carpet	2005	1,060		20	53	53	75	12
13	Framing & Drywall	2005	38,500		20	1,925	1,925	2,406	13
14	Electrical Work	2005	2,171		20	109	109	127	14
15	Flooring	2005	480		20	24	24	28	15
16	Window Treatment Installation	2005	627		20	31	31	34	16
17	Repair Flooring	2005	788		20	39	39	43	17
18	Computer & Telephone Cableing	2005	1,170		20	59	59	63	18
19	Exhaust Fans, Ductwork	2005	1,175		20	59	59	64	19
20	Electrical Work	2005	3,307		20	165	165	193	20
21	Recessed Pendants	2005	3,480		20	174	174	218	21
22	Plumbing & Ceramic Tile	2005	2,026		20	101	101	127	22
23	Carpet	2005	252		20	13	13	16	23
24	Counter Top	2005	394		20	20	20	25	24
25	Framing & Drywall	2005	19,067		20	953	953	1,112	25
26	Wallpaper	2005	30		20	1	1	2	26
27	2 A/C Units	2005	1,161		20	58	58	82	27
28	Drywall & Supplies	2005	1,925		20	96	96	136	28
29	Improvement	2005	111		20	6	6	6	29
30	Ductwork & Sheet Metal	2005	4,010		20	201	201	251	30
31	Improvement	2005	19,800		20	990	990	1,238	31
32	Remodeling Building Supplies	2005	3,489		20	174	174	204	32
33	Handrails	2005	541		20	27	27	36	33
34	TOTAL (lines 1 thru 33)		\$ 6,271,105	\$ 177,215		\$ 201,313	\$ 24,098	\$ 341,552	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:

01/01/06

Ending:

12/31/06**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		\$ 6,271,105	\$ 177,215		\$ 201,313	\$ 24,098	\$ 341,552	1
2	<u>Kewanee Copr - Improvement</u>	2005	1,050		20	53	53	66	2
3	<u>Door & Hardware</u>	2005	3,898		20	195	195	276	3
4	<u>Doors</u>	2005	2,985		20	149	149	211	4
5	<u>Demolition, Framing, Drywall</u>	2005	25,850		20	1,293	1,293	1,723	5
6	<u>Carpet</u>	2005	3,485		20	174	174	218	6
7	<u>Improvement</u>	2005	4,500		20	225	225	281	7
8	<u>Floor & Wall Tile</u>	2005	2,500		20	125	125	167	8
9	<u>Carpet, Vinyl Base & Floor Prep</u>	2005	445		20	22	22	28	9
10	<u>Carpet, Vinyl Base & Floor Prep</u>	2005	361		20	18	18	23	10
11	<u>Wallpaper</u>	2005	228		20	11	11	14	11
12	<u>Electrical Work</u>	2005	3,430		20	172	172	229	12
13	<u>Electrical Work</u>	2005	1,596		20	80	80	100	13
14	<u>Door Light</u>	2005	79		20	4	4	5	14
15	<u>Window & Door Wire Glass</u>	2005	100		20	5	5	6	15
16	<u>Door Wire Glass</u>	2005	551		20	28	28	34	16
17	<u>Electrical Materials</u>	2005	20		20	1	1	1	17
18	<u>Wallpaper Supplies</u>	2005	476		20	24	24	44	18
19	<u>Vinyl Flooring</u>	2005	6,034		20	302	302	553	19
20	<u>Wallpaper & Handrails</u>	2005	4,320		20	216	216	396	20
21	<u>Vinyl Flooring & Wallpaper</u>	2005	4,552		20	228	228	417	21
22	<u>Renovation Labor</u>	2005	5,600		20	280	280	490	22
23	<u>Vinyl Flooring & Wallpaper</u>	2005	7,729		20	386	386	676	23
24	<u>Renovation Labor</u>	2005	4,930		20	247	247	431	24
25	<u>Renovation Labor</u>	2005	4,000		20	200	200	333	25
26	<u>Wallpapering</u>	2005	3,050		20	152	152	254	26
27	<u>Vinyl Flooring & Wallpaper</u>	2005	7,366		20	368	368	583	27
28	<u>Renovation Labor</u>	2005	2,800		20	140	140	222	28
29	<u>Renovation Labor</u>	2005	4,000		20	200	200	333	29
30	<u>Vinyl Flooring & Wallpaper</u>	2005	2,003		20	100	100	150	30
31	<u>Renovation Labor</u>	2005	2,400		20	120	120	180	31
32	<u>Renovation Labor</u>	2005	3,600		20	180	180	270	32
33	<u>Renovation Labor</u>	2005	1,200		20	60	60	90	33
34	TOTAL (lines 1 thru 33)		\$ 6,386,243	\$ 177,215		\$ 207,071	\$ 29,856	\$ 350,356	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:

01/01/06

Ending:

12/31/06

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		\$ 6,386,243	\$ 177,215		\$ 207,071	\$ 29,856	\$ 350,356	1
2	Renovation Labor	2005	5,831		20	292	292	413	2
3	Data & Telephone Cableing, Smoke Detectors	2005	1,897		20	95	95	119	3
4	Relocate Fire Alarm Strobes & Pull Stations	2005	325		20	16	16	20	4
5	Flooring	2005	4,538		20	227	227	284	5
6	Flooring	2005	780		20	39	39	49	6
7	Wallpaper & Blinds	2005	4,826		20	241	241	302	7
8	Locking Sliding Glass Window	2005	942		20	47	47	59	8
9	Wallpaper	2005	14,173		20	709	709	1,417	9
10	Wallpaper	2005	1,442		20	72	72	144	10
11	Improvements	2005	1,937		20	97	97	105	11
12	Compressor Replacement*	2006	2,522		20	74	74	74	12
13	Building Addition*	2006	100,923		20	841	841	841	13
14	Therapy Mirrors	2006	3,611		20	90	90	90	14
15	16 Port Analog Pack*	2006	3,152		20	26	26	26	15
16	Chiller	2006	44,900		20	2,993	2,993	2,993	16
17	Chiller**	2006	(35,168)		20	(2,345)	(2,345)	(2,345)	17
18	Service Chiller	2006	1,626		20	108	108	108	18
19	Install Wallcoverings	2006	1,920		20	160	160	160	19
20	Electrical Work For Chiller**	2006	4,926		20	328	328	328	20
21	Sewage Pump	2006	899		20	67	67	67	21
22	* Added After 6/30/06 Capital Report	2006			20				22
23	** Added Prior To 6/30/06-Not Incd On Cap Report 6/30/06	2006			20				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)		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610		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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610		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:

01/01/06

Ending:

12/31/06

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 12J, Carried Forward	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610		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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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		\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610	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:

01/01/06

Ending:

12/31/06

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 12P, Carried Forward	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610		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)	\$ 6,552,245	\$ 177,215		\$ 211,248	\$ 34,033	\$ 355,610		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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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			1996	1996	\$ 20,105	\$	35	\$ 1,005	\$ 1,005	\$	4
5			1995	1995	5,614,638	29,959	35	160,418	130,459	184,050	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:

01/01/06

Ending:

12/31/06

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	29,959		161,423	131,464	184,050	

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:

01/01/06

Ending:

12/31/06

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:

01/01/06

Ending:

12/31/06

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: 01/01/06 Ending: 12/31/06

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	\$ 356,408	\$	\$ 49,782	\$ 49,782	10	\$ 212,231	71
72	Current Year Purchases	119,073		3,990	3,990	10	3,990	72
73	Fully Depreciated Assets	363,103				10	363,103	73
74								74
75	TOTALS	\$ 838,584	\$	\$ 53,772	\$ 53,772		\$ 579,324	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	\$	\$ 1,851	\$ 1,851	5	\$ 24,698	76
77		BUS	1999	66,022		6,602	6,602	5	49,516	77
78		98 FORD F250 PICKUP	2001	5,371				5	17,223	78
79		See Attached Schedule	1997	13,598		1,702	1,702	5	10,342	79
80	TOTALS			\$ 109,689	\$	\$ 10,155	\$ 10,155		\$ 101,779	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)		\$ 7,672,710	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 177,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 275,175	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 97,960	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,036,713	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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 13,662 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	Facility	2003 Car Lease	\$	\$ 6,239	17
18	Personal Portion			(5,380)	18
19					19
20					20
21	TOTAL		\$	\$ 859	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	\$		\$ 488,685	\$		\$ 488,685	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			131,968			131,968	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			525,219			525,219	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				334,055		334,055	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					148,681	20,576		169,257	13
14	TOTAL			\$		\$ 1,294,553	\$ 354,631		\$ 1,649,184	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: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 150,081	\$ 242,622	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,295,242	2,295,242	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,296	65,296	6
7	Other Prepaid Expenses	2,301	2,301	7
8	Accounts Receivable (owners or related parties)	626,969	626,969	8
9	Other(specify): <u>See Attached Schedule</u>	7,364	7,364	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,147,753	\$ 3,240,294	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		1,791,253	14
15	Leasehold Improvements, at Historical Cost	880,143	880,143	15
16	Equipment, at Historical Cost	926,503	926,503	16
17	Accumulated Depreciation (book methods)	(966,211)	(1,135,776)	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>	7,941	7,941	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 848,376	\$ 2,565,051	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,996,129	\$ 5,805,345	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,172,925	\$ 1,172,925	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(1,982)	(1,982)	28
29	Short-Term Notes Payable	3,848,839	3,848,839	29
30	Accrued Salaries Payable	104,850	104,850	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,864	57,864	31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,980	110,980	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>	169,202	1,502,429	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,462,678	\$ 6,795,905	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	320,844	320,844	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)	\$ 320,844	\$ 320,844	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,783,522	\$ 7,116,749	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,787,393)	\$ (1,311,404)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,996,129	\$ 5,805,345	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,200,332)	1
2	Restatements (describe):		2
3	<u>See Attached</u>	167,500	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,032,832)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	996,239	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	(750,800)	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)	\$ 245,439	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,787,393)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 8,578,202	1
2	Discounts and Allowances for all Levels	131,512	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,709,714	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,100,097	6
7	Oxygen	32,498	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,132,595	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	312,213	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,911	19
20	Radiology and X-Ray		20
21	Other Medical Services	91,304	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 426,428	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,281	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,281	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,270,023	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,513,168	31
32	Health Care	3,531,918	32
33	General Administration	1,984,420	33
B. Capital Expense			
34	Ownership	1,403,067	34
C. Ancillary Expense			
35	Special Cost Centers	1,740,417	35
36	Provider Participation Fee	100,794	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,273,784	40
41	Income before Income Taxes (line 30 minus line 40)**	996,239	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 996,239	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: 01/01/06

Ending:

12/31/06

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	432	440	\$ 17,273	\$ 39.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,013	26,751	858,534	32.09	3
4	Licensed Practical Nurses	23,037	24,027	686,423	28.57	4
5	CNAs & Orderlies	97,430	102,793	1,295,910	12.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,383	6,844	100,163	14.64	8
9	Activity Director	1,928	2,080	36,200	17.40	9
10	Activity Assistants	10,925	11,315	111,728	9.87	10
11	Social Service Workers	6,777	7,308	121,938	16.69	11
12	Dietician	1,816	2,080	53,258	25.60	12
13	Food Service Supervisor					13
14	Head Cook	6,904	7,718	104,242	13.51	14
15	Cook Helpers/Assistants	20,811	21,986	178,823	8.13	15
16	Dishwashers					16
17	Maintenance Workers	2,219	2,558	40,429	15.80	17
18	Housekeepers	33,345	35,144	301,654	8.58	18
19	Laundry	2,157	2,239	16,297	7.28	19
20	Administrator	2,076	2,180	130,419	59.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,592	8,183	245,807	30.04	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	1,880	2,080	36,928	17.75	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,918	2,918	90,633	31.06	33
34	TOTAL (lines 1 - 33)	253,643	268,644	\$ 4,426,659 *	\$ 16.48	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	193	\$ 8,602	01-03	35
36	Medical Director	Monthly	23,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	36	1,945	10-03	38
39	Pharmacist Consultant	Monthly	2,418	10-03	39
40	Physical Therapy Consultant	14	695	10a-03	40
41	Occupational Therapy Consultant	6	285	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	141	10a-03	43
44	Activity Consultant	105	5,852	11-03	44
45	Social Service Consultant	139	7,318	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	496	\$ 50,756		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	446	\$ 22,542	10-03	50
51	Licensed Practical Nurses	961	36,627	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,407	\$ 59,169		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/06

Ending: 12/31/06

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		
Aaron Mann 12/11-12/31/06	Administrator	0	\$ 5,298	Workers' Compensation Insurance	\$ 115,332	IDPH License Fee	\$		
Gregg Seeger 1/1-12/10/06	Administrator	0	125,121	Unemployment Compensation Insurance	48,795	Advertising: Employee Recruitment	33,598		
				FICA Taxes	331,222	Health Care Worker Background Check	3,167		
				Employee Health Insurance	83,612	(Indicate # of checks performed <u>303</u>)			
				Employee Meals	22,776	Patient Background Checks	193		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	965		
				401K Expense	8,771	Dues-ICLTC	7,350		
				Employee Benefits	37,999	Licenses and Fees	8,264		
						Advertising and Promotion	32,790		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 130,419						
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	
Resource Consulting - Management Fee			\$ 62,001				Out-of-State Travel	\$	
Senior Living Consultants - Management Fee			58,465						
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 120,466	TOTAL (agree to Schedule V, line 22, col.8)			\$ 648,507	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
FR&R	Accounting		\$ 20,205						
Camille Koehl	Accounting		2,111						
American Data	Computer		3,452						
CDW	Computer		10,265						
Computerized Business	Computer		2,132						
HDSI	Computer		7,205						
Terry Bathum	Computer		287						
Tom Braje	Computer		2,423						
Talx Corp	Unemployment Cons		1,808						
Personnel Planners	Unemployment Cons		914						
Life Safety Resources	Healthcare Consulting		1,200						
See Supplemental Schedule			64,679						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 116,681					\$ 5,336	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Arlington Rehab & Living Center

Report Period Beginning: 01/01/06 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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
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-\$9952
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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. \$ 54,334 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. \$ 100,794
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,776 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A 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