

Facility Name & ID Number Arlington Rehab & Living Center

0040899 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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>190</u>	Skilled (SNF)	<u>190</u>	<u>69,350</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>190</u>	TOTALS	<u>190</u>	<u>69,350</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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>28,586</u>	<u>4,698</u>	<u>11,840</u>	<u>45,124</u>	8
9	SNF/PED					9
10	ICF	<u>14,384</u>	<u>2,837</u>		<u>17,221</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,970</u>	<u>7,535</u>	<u>11,840</u>	<u>62,345</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.90%

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 10,154

Medicare Intermediary Wisconsin Physician Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	364,745	57,712	9,018	431,475		431,475		431,475		1
2	Food Purchase		309,596		309,596	(22,484)	287,112	(374)	286,738		2
3	Housekeeping	331,562	33,182		364,744		364,744		364,744		3
4	Laundry	12,643	24,623	1,253	38,519		38,519		38,519		4
5	Heat and Other Utilities			191,796	191,796		191,796	(10,530)	181,266		5
6	Maintenance	39,958	93,089	124,994	258,041		258,041		258,041		6
7	Other (specify):*										7
8	TOTAL General Services	748,908	518,202	327,061	1,594,171	(22,484)	1,571,687	(10,904)	1,560,783		8
	B. Health Care and Programs										
9	Medical Director			42,000	42,000		42,000		42,000		9
10	Nursing and Medical Records	3,139,566	161,464	10,849	3,311,879		3,311,879	(1,389)	3,310,490		10
10a	Therapy	105,070	120	1,187	106,377		106,377		106,377		10a
11	Activities	155,496	6,798	5,352	167,646		167,646		167,646		11
12	Social Services	131,647		4,985	136,632		136,632		136,632		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,531,779	168,382	64,373	3,764,534		3,764,534	(1,389)	3,763,145		16
	C. General Administration										
17	Administrative	169,640		119,783	289,423		289,423		289,423		17
18	Directors Fees										18
19	Professional Services			129,400	129,400	(730)	128,670	(3,866)	124,804		19
20	Dues, Fees, Subscriptions & Promotions			87,003	87,003		87,003	(43,391)	43,612		20
21	Clerical & General Office Expenses	243,383	8,151	207,903	459,437		459,437	(119,874)	339,563		21
22	Employee Benefits & Payroll Taxes			658,620	658,620	22,484	681,104	(43)	681,061		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,490	5,490		5,490	(543)	4,947		24
25	Other Admin. Staff Transportation			17,964	17,964		17,964		17,964		25
26	Insurance-Prop.Liab.Malpractice			19,106	19,106		19,106		19,106		26
27	Other (specify):*										27
28	TOTAL General Administration	413,023	8,151	1,245,269	1,666,443	21,754	1,688,197	(167,716)	1,520,481		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,693,710	694,735	1,636,703	7,025,148	(730)	7,024,418	(180,010)	6,844,408		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:

01/01/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			153,516	153,516		153,516	168,763	322,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			198,737	198,737		198,737	(90,038)	108,699			32
33	Real Estate Taxes			109,221	109,221	730	109,951		109,951			33
34	Rent-Facility & Grounds			979,914	979,914		979,914	(979,914)				34
35	Rent-Equipment & Vehicles			24,237	24,237		24,237	(10,046)	14,192			35
36	Other (specify):*											36
37	TOTAL Ownership			1,465,625	1,465,625	730	1,466,355	(911,234)	555,121			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		370,318	1,294,226	1,664,544		1,664,544	(145,914)	1,518,630			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,070	104,070		104,070	(45)	104,025			42
43	Other (specify):*	90,587			90,587		90,587	(90,587)	0			43
44	TOTAL Special Cost Centers	90,587	370,318	1,398,296	1,859,201		1,859,201	(236,546)	1,622,655			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,784,297	1,065,053	4,500,624	10,349,974		10,349,974	(1,327,790)	9,022,184			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: 01/01/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	103,627	30		9
10	Interest and Other Investment Income	(15,684)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(374)	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	(2,162)	21		18
19	Entertainment	(9,108)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,320)	21		24
25	Fund Raising, Advertising and Promotional	(41,042)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(356,945)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (422,008)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(905,782)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (905,782)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,327,790)		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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Patient Needs	\$ (1,337)	10	1
2 Marketing Wages	(98,587)	43	2
3 Bank Charges	(1,986)	23	3
4 Franchise Tax	(2,851)	23	4
5 Collection Fees	(3,623)	23	5
6 Out of State Seminar	(543)	24	6
7 Excess Bad Tax	(48)	42	7
8 Cable TV	(6,530)	68	8
9 Jury Duty Income	(52)	10	9
10 Copy Fees	(425)	23	10
11 PPA/Payroll Taxes	(43)	22	11
12 Legal Fees - Bldg. Co.	698	19	12
13 Management Fees - Bldg. Co.	(36,087)	17	13
14 Franchise Tax - Bldg. Co.	(993)	20	14
15 State Income Tax - Bldg. Co.	(1,414)	24	15
16 Trans Fees - Bldg. Co.	(210)	20	16
17 Accounting Fees - Bldg. Co.	(2,275)	19	17
18 Non-Allowable Auto Lease	(10,040)	35	18
19 Non-Allowable Legal Fees	(3,366)	19	19
20 Copy Dues	(2,349)	20	20
21 Non-Allowable Interest Expense	(177,500)	32	21
22			22
23			23
24			24
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95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(356,945)		101

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/07

Ending:

12/31/07**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	(374)											(374)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(10,530)											(10,530)	5
6	Maintenance													6
7	Other (specify):*													7
8	TOTAL General Services	(10,904)											(10,904)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,389)											(1,389)	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	(1,389)											(1,389)	16
	C. General Administration													
17	Administrative	(36,087)	36,087											17
18	Directors Fees													18
19	Professional Services	(6,839)	2,973										(3,866)	19
20	Fees, Subscriptions & Promotions	(44,594)	1,203										(43,391)	20
21	Clerical & General Office Expenses	(131,285)	11,411										(119,874)	21
22	Employee Benefits & Payroll Taxes	(43)											(43)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(543)											(543)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(219,390)	51,674										(167,716)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(231,684)	51,674										(180,010)	29

STATE OF ILLINOIS

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	103,627	65,136										168,763	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(193,274)	103,236										(90,038)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(979,914)										(979,914)	34
35	Rent-Equipment & Vehicles	(10,046)											(10,046)	35
36	Other (specify):*													36
37	TOTAL Ownership	(99,692)	(811,542)										(911,234)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(145,914)									(145,914)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(45)											(45)	42
43	Other (specify):*	(90,587)											(90,587)	43
44	TOTAL Special Cost Centers	(90,632)		(145,914)									(236,546)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(422,008)	(759,868)	(145,914)									(1,327,790)	45

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$ 979,914	Kedzie Home, LLC	100.00%	\$	\$ (979,914)	1
2	V	32 Interest	131	Kedzie Home, LLC			(131)	2
3	V	30 Depreciation		Kedzie Home, LLC		65,136	65,136	3
4	V	32 Interest Expense		Kedzie Home, LLC		103,367	103,367	4
5	V	19 Legal Fees		Kedzie Home, LLC		698	698	5
6	V	17 Management Fees		Kedzie Home, LLC		36,087	36,087	6
7	V	20 Franchise Taxes		Kedzie Home, LLC		993	993	7
8	V	21 State Income Tax		Kedzie Home, LLC		11,411	11,411	8
9	V	20 Trust Fees		Kedzie Home, LLC		210	210	9
10	V	19 Accounting Fees		Kedzie Home, LLC		2,275	2,275	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 980,045			\$ 220,177	\$ * (759,868)	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	\$ 1,222,219	Simply Rehab	100.00%	\$ 1,076,305	\$ (145,914)
16	V	10a Rehab Consulting		Simply Rehab	100.00%		
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,222,219			\$ 1,076,305	\$ * (145,914)

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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.

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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	7.00	14.00%	Mgmt Fee	\$ 58,272	17-3	1
2	Patrick Finn	Owner	Administrative	4.00%	See Attached	7.00	14.00%	Mgmt Fee	61,511	17-3	2
3	Aaron Mann	Relative	Administrator	None	None	40.00	100.00%	Salary	87,324	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 207,107		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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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					1,076,305	1
2	10a	Ancillary Rehab	Direct Allocation						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				\$	\$		\$ 1,076,305	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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				146,766			21,146	6
7	Shareholder Loan	X		Working Capital				2,810,103			113,331	7
8	See Supplemental Schedule											
9	TOTAL Facility Related											
	B. Non-Facility Related*											
10	Interest Income		X								(15,683)	10
11	Interest Income - Bldg. Co		X								(131)	11
12											(177,590)	12
13	See Supplemental Schedule											
14	TOTAL Non-Facility Related											
15	TOTALS (line 9+line14)											
							\$	\$			\$	15
								3,903,568			108,699	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/07 Ending: 12/31/07

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			\$	\$ 946,699		\$ 64,259	8									
9	Kedzie Home		X	Working Capital						103,367	9									
10	Adjusted out page 5																			
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 2006 report.		\$ <u>110,980</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>107,415</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>(3,565)</u>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>112,786</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.)		\$ <u>730</u>	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>2,160</u> For <u>2002+ 2003</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>109,951</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<u>123,605</u>	8
	2003	<u>132,625</u>	9
	2004	<u>126,323</u>	10
	2005	<u>105,696</u>	11
	2006	<u>107,415</u>	12
RE Tax Accrual = \$107,415 x 1.05 = \$112,786			

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>Long Term Care Property</u>	<u>15-31-201-083</u>	\$ <u>5,500.09</u>	\$ <u>5,500.09</u>
2. <u>Long Term Care Property</u>	<u>15-31-201-082</u>	\$ <u>101,915.06</u>	\$ <u>101,915.06</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>107,415.15</u>	\$ <u>107,415.15</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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:

01/01/07

Ending:

12/31/07

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	1,515	1,515	18,858	9
10	Various		1997		34,251		20	1,712	1,712	15,815	10
11	Various		1998		115,118		20	5,755	5,755	53,802	11
12	Various		1999		8,794		20	439	439	3,312	12
13	Various		2000		5,943		20	553	553	4,322	13
14	Various		2001		11,296		20	566	566	3,698	14
15	Various		2002		41,668		20	4,167	4,167	22,364	15
16	Various		2003		12,640		20	1,264	1,264	5,437	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:

01/01/07

Ending:

12/31/07

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	65,136		161,423	96,287	1,134,989	67
68								68
69			153,516			(153,516)		69
70		\$ 5,896,028	\$ 218,652		\$ 177,394	\$ (41,258)	\$ 1,262,597	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:

01/01/07

Ending:

12/31/07

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		\$ 5,896,028	\$ 218,652		\$ 177,394	\$ (41,258)	\$ 1,262,597	1
2	Generator Repairs	2004	1,437		20	144	144	575	2
3	Wallpaper 100 Unit Dining Room	2004	1,650		20	165	165	646	3
4	Wallpaper Supplies	2004	271		20	27	27	106	4
5	24 Call Cord Assemblys	2004	831		20	83	83	326	5
6	6 Call Cord Assemblys, 12 Hand Showers	2004	392		20	39	39	154	6
7	Paint Base Cove Casing Plugs	2004	632		20	63	63	248	7
8	Loadbank Of Generator	2004	1,019		20	102	102	408	8
9	Flooring, Ceiling, Electrical, Plumbing Work	2004	15,671		20	1,567	1,567	5,746	9
10	Thermopane Glass	2004	712		20	71	71	267	10
11	Water Storage Tank	2004	17,000		20	1,700	1,700	6,092	11
12	Disposer Sink Mounted 208 Volts	2004	2,033		20	203	203	712	12
13	Repl Condenser Fan & Motor	2004	1,002		20	100	100	351	13
14	Emergency Service For 2 Failed Pump Sys	2004	57,849		20	5,785	5,785	19,765	14
15	2 Electronic Closers	2004	1,070		20	107	107	348	15
16	10 6 Hp Motors	2004	710		20	71	71	231	16
17	Electrical Work	2004	633		20	63	63	195	17
18	New Phone System Setup	2005	765		20	38	38	92	18
19	New Phone System Setup	2005	1,125		20	56	56	136	19
20	New Phone System Setup	2005	841		20	42	42	102	20
21	New Phone System Setup	2005	275		20	14	14	33	21
22	Walk-In Freezer Door	2005	1,350		20	68	68	141	22
23	Duct Work For Dishwasher	2005	3,406		20	170	170	511	23
24	Drapes & Blinds	2005	23,871		20	1,194	1,194	3,481	24
25	Kitchen Construction	2005	307		20	15	15	45	25
26	Kitchen Construction	2005	1,599		20	80	80	233	26
27	Hallway Remodel	2005	748		20	37	37	109	27
28	Floor Drain Pipes Installation	2005	5,000		20	250	250	729	28
29	Disassemble Existing Plumbing	2005	18,465		20	923	923	2,693	29
30	Kitchen Construction	2005	403		20	20	20	57	30
31	Kitchen Construction	2005	2,192		20	110	110	311	31
32	Kitchen Construction	2005	120		20	6	6	17	32
33	Kitchen Construction	2005	178		20	9	9	24	33
34	TOTAL (lines 1 thru 33)		\$ 6,059,585	\$ 218,652		\$ 190,716	\$ (27,936)	\$ 1,307,481	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:

01/01/07

Ending:

12/31/07

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		\$ 6,059,585	\$ 218,652		\$ 190,716	\$ (27,936)	\$ 1,307,481	1
2	Townsquare Board	2005	1,586		20	79	79	218	2
3	Well Leak Repair	2005	1,063		20	53	53	146	3
4	Boiler Coil Replacement	2005	3,279		20	164	164	437	4
5	Improvement	2005	227		20	11	11	29	5
6	Improvement	2005	831		20	42	42	107	6
7	Hvac Motors	2005	550		20	28	28	69	7
8	Shower Materials	2005	1,049		20	52	52	127	8
9	Carpet	2005	1,750		20	88	88	211	9
10	Water Filtration	2005	5,800		20	290	290	677	10
11	Chiller Repairs	2005	4,044		20	202	202	472	11
12	Chiller Repairs	2005	735		20	37	37	95	12
13	Chiller Repairs	2005	1,614		20	81	81	195	13
14	Removal Of Damaged Panic Bar Hardware	2005	2,014		20	101	101	227	14
15	Bypass & Chloring Meter Installation	2005	3,476		20	174	174	391	15
16	Mobile Intermediate Hydrocollator Tank	2005	1,197		20	60	60	135	16
17	Chiller Repairs	2005	800		20	40	40	90	17
18	Aggrecko	2005	8,812		20	441	441	991	18
19	Work Order	2005	621		20	31	31	70	19
20	Building Remodeling Project	2005	937		20	47	47	105	20
21	Flowmeter & Metering Pump	2005	2,228		20	111	111	251	21
22	Colonial Grids	2005	1,000		20	50	50	104	22
23	End Caps & Hand Rails	2005	10,247		20	512	512	1,067	23
24	Fire Alarm Panel Repairs	2005	853		20	43	43	89	24
25	55 Gallon Tank & Saddle Clamp	2005	1,818		20	91	91	189	25
26	Fire Alarm Panel Repairs	2005	1,406		20	70	70	146	26
27	Wallpaper	2005	1,484		20	74	74	204	27
28	Valances	2005	22,535		20	1,127	1,127	3,193	28
29	Wallpaper	2005	767		20	38	38	102	29
30	Room Signs	2005	2,216		20	111	111	314	30
31	Carpet	2005	6,011		20	301	301	776	31
32	Valances	2005	10,904		20	545	545	1,363	32
33	Blinds & Wallpaper	2005	1,091		20	55	55	136	33
34	TOTAL (lines 1 thru 33)		\$ 6,162,530	\$ 218,652		\$ 195,865	\$ (22,787)	\$ 1,320,207	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:

01/01/07

Ending:

12/31/07

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		\$ 6,162,530	\$ 218,652		\$ 195,865	\$ (22,787)	\$ 1,320,207	1
2	Carpet	2005	3,011		20	151	151	389	2
3	Carpet	2005	1,060		20	53	53	128	3
4	Framing & Drywall	2005	38,500		20	1,925	1,925	4,331	4
5	Electrical Work	2005	2,171		20	109	109	235	5
6	Flooring	2005	480		20	24	24	52	6
7	Window Treatment Installation	2005	627		20	31	31	65	7
8	Repair Flooring	2005	788		20	39	39	82	8
9	Computer & Telephone Cableing	2005	1,170		20	59	59	122	9
10	Exhaust Fans, Ductwork	2005	1,175		20	59	59	122	10
11	Electrical Work	2005	3,307		20	165	165	358	11
12	Recessed Pendants	2005	3,480		20	174	174	392	12
13	Plumbing & Ceramic Tile	2005	2,026		20	101	101	228	13
14	Carpet	2005	252		20	13	13	28	14
15	Counter Top	2005	394		20	20	20	44	15
16	Framing & Drywall	2005	19,067		20	953	953	2,066	16
17	Wallpaper	2005	30		20	1	1	3	17
18	2 A/C Units	2005	1,161		20	58	58	140	18
19	Drywall & Supplies	2005	1,925		20	96	96	233	19
20	Improvement	2005	111		20	6	6	12	20
21	Ductwork & Sheet Metal	2005	4,010		20	201	201	451	21
22	Improvement	2005	19,800		20	990	990	2,228	22
23	Remodeling Building Supplies	2005	3,489		20	174	174	378	23
24	Handrails	2005	541		20	27	27	63	24
25	Kewanee Copr - Improvement	2005	1,050		20	53	53	118	25
26	Door & Hardware	2005	3,898		20	195	195	471	26
27	Doors	2005	2,985		20	149	149	361	27
28	Demolition, Framing, Drywall	2005	25,850		20	1,293	1,293	3,016	28
29	Carpet	2005	3,485		20	174	174	392	29
30	Improvement	2005	4,500		20	225	225	506	30
31	Floor & Wall Tile	2005	2,500		20	125	125	292	31
32	Carpet, Vinyl Base & Floor Prep	2005	445		20	22	22	50	32
33	Carpet, Vinyl Base & Floor Prep	2005	361		20	18	18	41	33
34	TOTAL (lines 1 thru 33)		\$ 6,316,179	\$ 218,652		\$ 203,548	\$ (15,104)	\$ 1,337,604	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:

01/01/07

Ending:

12/31/07

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		\$ 6,316,179	\$ 218,652		\$ 203,548	\$ (15,104)	\$ 1,337,604	1
2	Wallpaper	2005	228		20	11	11	26	2
3	Electrical Work	2005	3,430		20	172	172	400	3
4	Electrical Work	2005	1,596		20	80	80	180	4
5	Door Light	2005	79		20	4	4	9	5
6	Window & Door Wire Glass	2005	100		20	5	5	11	6
7	Door Wire Glass	2005	551		20	28	28	62	7
8	Electrical Materials	2005	20		20	1	1	2	8
9	Wallpaper Supplies	2005	476		20	24	24	67	9
10	Vinyl Flooring	2005	6,034		20	302	302	855	10
11	Wallpaper & Handrails	2005	4,320		20	216	216	612	11
12	Vinyl Flooring & Wallpaper	2005	4,552		20	228	228	645	12
13	Renovation Labor	2005	5,600		20	280	280	770	13
14	Vinyl Flooring & Wallpaper	2005	7,729		20	386	386	1,063	14
15	Renovation Labor	2005	4,930		20	247	247	678	15
16	Renovation Labor	2005	4,000		20	200	200	533	16
17	Wallpapering	2005	3,050		20	152	152	407	17
18	Vinyl Flooring & Wallpaper	2005	7,366		20	368	368	951	18
19	Renovation Labor	2005	2,800		20	140	140	362	19
20	Renovation Labor	2005	4,000		20	200	200	533	20
21	Vinyl Flooring & Wallpaper	2005	2,003		20	100	100	250	21
22	Renovation Labor	2005	2,400		20	120	120	300	22
23	Renovation Labor	2005	3,600		20	180	180	450	23
24	Renovation Labor	2005	1,200		20	60	60	150	24
25	Renovation Labor	2005	5,831		20	292	292	705	25
26	Data & Telephone Cableing, Smoke Detectors	2005	1,897		20	95	95	213	26
27	Relocate Fire Alarm Strobes & Pull Stations	2005	325		20	16	16	37	27
28	Flooring	2005	4,538		20	227	227	511	28
29	Flooring	2005	780		20	39	39	88	29
30	Wallpaper & Blinds	2005	4,826		20	241	241	543	30
31	Locking Sliding Glass Window	2005	942		20	47	47	106	31
32	Wallpaper	2005	14,173		20	709	709	2,126	32
33	Wallpaper	2005	1,442		20	72	72	216	33
34	TOTAL (lines 1 thru 33)		\$ 6,420,997	\$ 218,652		\$ 208,790	\$ (9,862)	\$ 1,351,465	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:

01/01/07

Ending:

12/31/07

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		\$ 6,420,997	\$ 218,652		\$ 208,790	\$ (9,862)	\$ 1,351,465	1
2	Improvements	2005	1,937		20	97	97	202	2
3	Compressor Replacement	2006	2,522		20	126	126	200	3
4	Building Addition	2006	100,923		20	10,092	10,092	10,933	4
5	Therapy Mirrirs	2006	3,611		20	361	361	451	5
6	16 Port Analog Pack	2006	3,152		20	315	315	341	6
7	Chiller	2006	44,900		20	4,490	4,490	7,483	7
8	Chiller	2006	(35,168)		20	(3,517)	(3,517)	(5,861)	8
9	Service Chiller	2006	1,626		20	163	163	271	9
10	Install Wallcoverings	2006	1,920		20	192	192	352	10
11	Electrical Work For Chiller	2006	4,926		20	493	493	821	11
12	Sewage Pump	2006	899		20	90	90	157	12
13	Remodeling - Carpeting, Wallcovering	2006	11,344		20	567	567	567	13
14	Sprinkler Repairs/Pump Room	2007	5,301		20	442	442	442	14
15	Rebuilt Laundry Boiler	2007	3,390		20	235	235	235	15
16	New Domestic Water Tretment System	2007	13,178		20	769	769	769	16
17	Restore Unit Electronic Door	2007	2,363		20	98	98	98	17
18	Lobby Remodeling & Flooring	2007	3,413		20	284	284	284	18
19	Office & Copy Room Remodeling	2007	3,120		20	130	130	130	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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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
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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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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:

01/01/07

Ending:

12/31/07

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 12H, Carried Forward	\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340		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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340		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:

01/01/07

Ending:

12/31/07

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		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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:

01/01/07

Ending:

12/31/07

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		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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:

01/01/07

Ending:

12/31/07

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 12K, Carried Forward		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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
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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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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:

01/01/07

Ending:

12/31/07

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 12L, Carried Forward		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 12M, Carried Forward	\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340		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)	\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340		34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 12N, Carried Forward	\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340		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)	\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340		34

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Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 12O, Carried Forward		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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)		\$ 6,594,354	\$ 218,652		\$ 224,217	\$ 5,565	\$ 1,369,340	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1996	1996	\$ 20,105	\$	35	\$ 1,005	\$ 1,005	\$ 12,062	4
5			1995	1995	5,614,638	65,136	35	160,418	95,282	1,122,927	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:

01/01/07

Ending:

12/31/07

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		65,136		161,423	
							96,287	
								1,134,989

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/07

Ending:

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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
9	Improvement Type**										
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:

01/01/07

Ending:

12/31/07

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: 01/01/07 Ending: 12/31/07

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	\$ 462,378	\$	\$ 58,831	\$ 58,831	10	\$ 258,292	71
72	Current Year Purchases	92,066		30,927	30,927	10	30,927	72
73	Fully Depreciated Assets	380,829				10	380,829	73
74								74
75	TOTALS	\$ 935,273	\$	\$ 89,758	\$ 89,758		\$ 670,048	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	\$	\$	\$	5	\$ 24,698	76
77		BUS	1999	66,022		6,602	6,602	5	56,118	77
78		98 FORD F250 PICKUP	2001	5,371				5	17,223	78
79		See Attached Auto Schedule	1997	13,598		1,702	1,702	5	12,044	79
80	TOTALS			\$ 109,689	\$	\$ 8,304	\$ 8,304		\$ 110,083	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)	\$ 7,811,508	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,652	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,279	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 103,627	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,149,471	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 14,191 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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	\$		\$ 527,646	\$		\$ 527,646	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			146,423			146,423	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			525,288			525,288	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				339,329		339,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					94,869	30,989		125,858	13
14	TOTAL			\$		\$ 1,294,226	\$ 370,318		\$ 1,664,544	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: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 86,081	\$ 165,904	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,221,611	2,221,611	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,718	72,718	6
7	Other Prepaid Expenses	12,109	12,109	7
8	Accounts Receivable (owners or related parties)	570,390	570,390	8
9	Other(specify): <u>See Attached Schedule</u>	119,553	119,553	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,082,962	\$ 3,162,785	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		1,791,252	14
15	Leasehold Improvements, at Historical Cost	922,356	922,356	15
16	Equipment, at Historical Cost	1,007,121	1,007,121	16
17	Accumulated Depreciation (book methods)	(1,147,615)	(1,396,802)	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)	\$ 789,803	\$ 2,426,855	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,872,765	\$ 5,589,640	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,036,511	\$ 1,036,510	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(2,816)	(2,816)	28
29	Short-Term Notes Payable	3,756,802	3,756,802	29
30	Accrued Salaries Payable	242,597	242,597	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,792	28,792	31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,786	112,786	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>	128,468	1,455,242	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,303,140	\$ 6,629,913	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	146,766	146,766	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)	\$ 146,766	\$ 146,766	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,449,906	\$ 6,776,679	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,577,141)	\$ (1,187,039)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,872,765	\$ 5,589,640	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,787,393)	1
2	Restatements (describe):		2
3	<u>Equity Restatement - See Attached</u>	(133,209)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,920,602)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,912,461	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	(1,569,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 343,461	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)	\$ (1,577,141)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 9,359,170	1
2	Discounts and Allowances for all Levels	356,040	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,715,210	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,065,736	6
7	Oxygen	32,120	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,097,856	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	357,195	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,342	19
20	Radiology and X-Ray	9,965	20
21	Other Medical Services	31,310	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 427,812	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,684	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,684	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	5,873	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,873	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,262,435	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,594,171	31
32	Health Care	3,764,534	32
33	General Administration	1,666,443	33
B. Capital Expense			
34	Ownership	1,465,625	34
C. Ancillary Expense			
35	Special Cost Centers	1,755,131	35
36	Provider Participation Fee	104,070	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,349,974	40
41	Income before Income Taxes (line 30 minus line 40)**	1,912,461	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,912,461	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: 01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,090	1,115	\$ 45,017	\$ 40.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,857	25,334	790,438	31.20	3
4	Licensed Practical Nurses	29,870	31,455	926,209	29.45	4
5	CNAs & Orderlies	97,496	104,183	1,340,047	12.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,416	7,016	105,070	14.98	8
9	Activity Director	1,019	1,179	20,439	17.34	9
10	Activity Assistants	11,580	12,220	135,057	11.05	10
11	Social Service Workers	6,730	7,254	131,647	18.15	11
12	Dietician	1,906	2,078	57,760	27.80	12
13	Food Service Supervisor					13
14	Head Cook	6,712	7,533	104,579	13.88	14
15	Cook Helpers/Assistants	21,325	22,603	202,406	8.95	15
16	Dishwashers					16
17	Maintenance Workers	1,929	2,055	39,958	19.44	17
18	Housekeepers	32,545	35,154	331,562	9.43	18
19	Laundry	1,364	1,515	12,643	8.35	19
20	Administrator	3,857	4,080	169,640	41.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,260	14,959	243,383	16.27	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	1,901	2,086	37,855	18.15	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,091	2,091	90,587	43.32	33
34	TOTAL (lines 1 - 33)	265,948	283,910	\$ 4,784,297 *	\$ 16.85	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	202	\$ 9,018	01-03	35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	157	8,431	10-03	38
39	Pharmacist Consultant	Monthly	2,418	10-03	39
40	Physical Therapy Consultant	8	494	10a-03	40
41	Occupational Therapy Consultant	7	439	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	254	10a-03	43
44	Activity Consultant	94	5,352	11-03	44
45	Social Service Consultant	80	4,985	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	552	\$ 73,391		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	Administrator		\$ 87,324	Workers' Compensation Insurance	\$ 133,195	IDPH License Fee	\$ 995		
Greg Seeger	Administrator		82,316	Unemployment Compensation Insurance	49,429	Advertising: Employee Recruitment	21,072		
				FICA Taxes	354,543	Health Care Worker Background Check	2,430		
				Employee Health Insurance	80,352	(Indicate # of checks performed <u>243</u>)			
				Employee Meals	22,484	Patient Background Checks <u>248</u>	2,555		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,437		
				Other Employee Benefits	31,288	Dues - ICLTC	9,952		
				401K Matching Expense	9,769	Licenses Inspection & Fees	5,171		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 169,640						
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 Fees			\$ 61,511				Out-of-State Travel	\$	
Senior Living Consultants - Management Fees			58,272						
							In-State Travel		
							Seminar Expense	4,947	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 119,783	TOTAL (agree to Schedule V, line 22, col.8)			\$ 681,060	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 Fees	\$ 21,685							
Camille Koehl	Accounting Fees	263							
Personnel Planners	Unemployment Consulting	1,200							
American Data	Computer Services	3,881							
CDW Government	Computer Services	15,891							
Computerized Business	Computer Services	2,067							
Health Data	Computer Services	6,994							
Konica Minolta	Computer Services	26							
Mundo Corp	Computer Services	357							
S. Nichols Enterprises	Computer Services	75							
Carnation Software	Computer Services	185							
See Supplemental Schedule		76,777							
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.)			\$ 129,401					\$ 4,947	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Arlington Rehab & Living Center

Report Period Beginning: 01/01/07 Ending: 12/31/07

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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$9,952
- (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. \$ 58,754 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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. \$ 104,025
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. \$ 22,484 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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT