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

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>69,540</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>69,540</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>47,373</u>	<u>7,590</u>	<u>9,693</u>	<u>64,656</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>47,373</u>	<u>7,590</u>	<u>9,693</u>	<u>64,656</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.98%

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 190 and days of care provided 8,833

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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
	<b>A. General Services</b>										
1	Dietary	393,854	49,716	18,083	461,653		461,653		461,653		1
2	Food Purchase		314,071		314,071	(21,960)	292,111	(367)	291,744		2
3	Housekeeping	322,750	45,521		368,271		368,271		368,271		3
4	Laundry	37,562	32,208	3,200	72,970		72,970		72,970		4
5	Heat and Other Utilities			215,041	215,041		215,041	(12,445)	202,596		5
6	Maintenance	47,654	118,975	656,480	823,109		823,109	(624,359)	198,750		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>801,820</b>	<b>560,491</b>	<b>892,804</b>	<b>2,255,115</b>	<b>(21,960)</b>	<b>2,233,155</b>	<b>(637,171)</b>	<b>1,595,984</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			28,500	28,500		28,500		28,500		9
10	Nursing and Medical Records	3,452,483	174,187	12,969	3,639,639		3,639,639	(4,386)	3,635,253		10
10a	Therapy	118,441	4,801	436	123,678		123,678		123,678		10a
11	Activities	134,690	7,166	5,582	147,438		147,438		147,438		11
12	Social Services	167,145		5,963	173,108		173,108		173,108		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,872,759</b>	<b>186,154</b>	<b>53,450</b>	<b>4,112,363</b>		<b>4,112,363</b>	<b>(4,386)</b>	<b>4,107,977</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	118,279		100,218	218,497		218,497		218,497		17
18	Directors Fees										18
19	Professional Services			250,941	250,941		250,941	(6,278)	244,663		19
20	Dues, Fees, Subscriptions & Promotions			79,300	79,300		79,300	(33,397)	45,903		20
21	Clerical & General Office Expenses	438,772	9,828	333,851	782,451		782,451	(238,363)	544,088		21
22	Employee Benefits & Payroll Taxes			729,149	729,149	21,960	751,109		751,109		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,564	8,564		8,564		8,564		24
25	Other Admin. Staff Transportation			18,894	18,894		18,894		18,894		25
26	Insurance-Prop.Liab.Malpractice			16,311	16,311		16,311		16,311		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>557,051</b>	<b>9,828</b>	<b>1,537,228</b>	<b>2,104,107</b>	<b>21,960</b>	<b>2,126,067</b>	<b>(278,038)</b>	<b>1,848,029</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,231,630</b>	<b>756,473</b>	<b>2,483,482</b>	<b>8,471,585</b>		<b>8,471,585</b>	<b>(919,595)</b>	<b>7,551,990</b>		<b>29</b>

\*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:

01/01/08

Ending:

12/31/08

## 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
	<b>D. Ownership</b>										
30	Depreciation			269,027	269,027	269,027	127,075	396,102			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			235,082	235,082	235,082	(213,151)	21,931			32
33	Real Estate Taxes			105,988	105,988	105,988		105,988			33
34	Rent-Facility & Grounds			1,037,983	1,037,983	1,037,983	(1,037,983)				34
35	Rent-Equipment & Vehicles			18,928	18,928	18,928	(5,489)	13,439			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,667,008	1,667,008	1,667,008	(1,129,548)	537,460			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		309,618	1,106,933	1,416,551	1,416,551	(53,146)	1,363,405			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops			1,572	1,572	1,572		1,572			41
42	Provider Participation Fee			104,310	104,310	104,310		104,310			42
43	Other (specify):*	76,937			76,937	76,937	(76,937)				43
44	<b>TOTAL Special Cost Centers</b>	76,937	309,618	1,212,815	1,599,370	1,599,370	(130,083)	1,469,287			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	5,308,567	1,066,091	5,363,305	11,737,963	11,737,963	(2,179,226)	9,558,737			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: 01/01/08

Ending: 12/31/08

**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	(12,445)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	51,332	30		9
10	Interest and Other Investment Income	(283)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(367)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,960)	21		18
19	Entertainment	(8,065)	21		19
20	Contributions	(30)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(194,525)	21		24
25	Fund Raising, Advertising and Promotional	(26,558)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(21,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,109,389)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,325,290)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(853,936)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (853,936)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (2,179,226)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Arlington Rehab & Living Center

ID# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Jury Duty Income	\$ (17)	10	1
2	Patient Needs	(4,369)	10	2
3	Marketing Wages	(76,937)	43	3
4	Bank Charges	(6,807)	21	4
5	Franchise Tax	(2,851)	21	5
6	Collection Fees	(360)	21	6
7	Medical Records Income	(795)	21	7
8	PPA - Therapy Charges Adjustments	(14,336)	39	8
9	Bank Charges - Bldg. Co	(170)	21	9
10	Accounting Fees - Bldg. Co.	(2,017)	19	10
11	Legal Fees - Bldg. Co.	(711)	19	11
12	Management Fees - Bldg. Co.	(47,896)	17	12
13	Franchise Tax - Bldg. Co	(650)	20	13
14	State Income Tax - Bldg. Co.	(10,218)	21	14
15	Trust Fees - Bldg. Co.	(520)	20	15
16	Non-Allowable Legal Fees	(6,278)	19	16
17	Capitalized R&M	(624,359)	06	17
18	Cope Dues	(6,809)	20	18
19	Non-Allowable Interest Expense	(297,800)	32	19
20	Non-Allowable Auto Lease	(5,489)	35	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,109,389)		49

Arlington Rehab & Living Center

ID# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Reference	Sch. V Line
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/08

Ending:

12/31/08**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)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(367)											(367)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,445)											(12,445)	5
6	Maintenance	(624,359)											(624,359)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(637,171)</b>											<b>(637,171)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(4,386)											(4,386)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(4,386)</b>											<b>(4,386)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(47,896)	47,896											17
18	Directors Fees													18
19	Professional Services	(9,006)	2,728										(6,278)	19
20	Fees, Subscriptions & Promotions	(34,567)	1,170										(33,397)	20
21	Clerical & General Office Expenses	(248,751)	10,388										(238,363)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(340,220)</b>	<b>62,182</b>										<b>(278,038)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(981,777)</b>	<b>62,182</b>										<b>(919,595)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	51,332	75,743										127,075	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(298,083)	84,932										(213,151)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,037,983)										(1,037,983)	34
35	Rent-Equipment & Vehicles	(5,489)											(5,489)	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(252,240)</b>	<b>(877,308)</b>										<b>(1,129,548)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(14,336)		(38,810)									(53,146)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(76,937)											(76,937)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(91,273)</b>		<b>(38,810)</b>									<b>(130,083)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(1,325,290)</b>	<b>(815,126)</b>	<b>(38,810)</b>									<b>(2,179,226)</b>	<b>45</b>

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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.
				(See Attached)		

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	\$ 1,037,983	Kedzie Home, LLC	100.00%	\$	\$ (1,037,983)	1
2	V	32 Interest	54	Kedzie Home, LLC			(54)	2
3	V	21 Bank Charges		Kedzie Home, LLC		170	170	3
4	V	30 Depreciation		Kedzie Home, LLC		75,743	75,743	4
5	V	32 Interest Expense		Kedzie Home, LLC		84,986	84,986	5
6	V	19 Accounting Fees		Kedzie Home, LLC		2,017	2,017	6
7	V	19 Legal Fees		Kedzie Home, LLC		711	711	7
8	V	17 Management Fees		Kedzie Home, LLC		47,896	47,896	8
9	V	20 Franchise Tax		Kedzie Home, LLC		650	650	9
10	V	21 State Income Tax		Kedzie Home, LLC		10,218	10,218	10
11	V	20 Trust Fees		Kedzie Home, LLC		520	520	11
12	V							12
13	V							13
14	Total		\$ 1,038,037			\$ 222,911	\$ * (815,126)	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	\$ 1,029,288	Simply Rehab	100.00%	\$ 990,478	\$	(38,810)	15
16	V	10a Rehab Consulting		Simply Rehab	100.00%				16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,029,288			\$ 990,478	\$ *	(38,810)	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

**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: 01/01/08

Ending: 12/31/08

**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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

**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: 01/01/08

Ending: 12/31/08

**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: 01/01/08

Ending: 12/31/08

**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: 01/01/08

Ending: 12/31/08

**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: 01/01/08 Ending: 12/31/08

## 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	\$ 61,022	17-3	1
2	Parrick Finn	Owner	Administrative	4.00%	See Attached	7.00	19.44%	Mgmt Fee	39,196	17-3	2
3	Aaron Mann	Relative	Administrator	None	See Attached	40.00	100.00%	Salary	112,840	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 213,058		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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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					990,478	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				\$	\$		\$ 990,478	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5	See Supplemental Schedule											
	<b>Working Capital</b>											
6	CIB Bank		X	Line of Credit				323,010			22,269	6
7	Venture Fund	X		Working Capital				1,386,523			100,881	7
8	See Supplemental Schedule											
9	<b>TOTAL Facility Related</b>											
	<b>B. Non-Facility Related*</b>											
10	Interest Income		X								(283)	10
11	Interest Income - Bldg. Co		X								(54)	11
12												12
13	See Supplemental Schedule											
14	<b>TOTAL Non-Facility Related</b>											
15	<b>TOTALS (line 9+line14)</b>											
							\$	\$ 4,488,398			\$ 21,932	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8	Shareholder Loan	X		Working Capital			\$	\$ 2,778,865		\$ 111,933	8									
9	Kedzie Home		X	Working Capital						84,986	9									
10	Adjusted out p.5A									(297,800)	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Working Capital</b>									(100,881)	14									
<b>B. Non-Facility Related*</b>																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</b>										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><b>Important</b>, 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 2007 report.		\$ 112,786	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.)		\$ 106,719	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (6,067)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 112,055	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 105,988	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	132,625	8
	2004	126,323	9
	2005	105,696	10
	2006	107,415	11
	2007	106,719	12
<b>RE Tax Accrual = \$106,719 x 1.05 = \$112,055</b>			
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-31-201-082</u>	<u>Long Term Care Property</u>	<u>\$ 106,719.27</u>	<u>\$ 106,719.27</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	<b>\$ 106,719.27</b>	<b>\$ 106,719.27</b>

**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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</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        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:

01/01/08 Ending:

12/31/08

**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	<b>TOTALS</b>	<b>132,000</b>		<b>\$ 172,192</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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
		<b>Improvement Type**</b>									
9	Various		1996		31,575		20	1,515	1,515	20,372	9
10	Various		1997		34,251		20	1,712	1,712	17,527	10
11	Various		1998		115,118		20	5,755	5,755	59,555	11
12	Various		1999		8,794		20	439	439	3,751	12
13	Various		2000		5,943		20	553	553	4,876	13
14	Various		2001		11,296		20	566	566	4,263	14
15	Various		2002		41,668		20	4,167	4,167	26,531	15
16	Various		2003		12,640		20	1,264	1,264	6,700	16
17	Various		2004		102,912		20	10,290	10,290	46,459	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:

01/01/08

Ending:

12/31/08

**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	75,743		161,423	85,680	1,296,412	67
68								68
69			269,027			(269,027)		69
70		\$ 5,998,940	\$ 344,770		\$ 187,684	\$ (157,086)	\$ 1,486,446	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:

01/01/08

Ending:

12/31/08**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,998,940	\$ 344,770		\$ 187,684	\$ (157,086)	\$ 1,486,446	1
2	New Phone System Setup	2005	765		20	38	38	131	2
3	New Phone System Setup	2005	1,125		20	56	56	192	3
4	New Phone System Setup	2005	841		20	42	42	144	4
5	New Phone System Setup	2005	275		20	14	14	47	5
6	Walk-In Freezer Door	2005	1,350		20	68	68	208	6
7	Duct Work For Dishwasher	2005	3,406		20	170	170	681	7
8	Drapes & Blinds	2005	23,871		20	1,194	1,194	4,675	8
9	Kitchen Construction	2005	307		20	15	15	60	9
10	Kitchen Construction	2005	1,599		20	80	80	313	10
11	Hallway Remodel	2005	748		20	37	37	146	11
12	Floor Drain Pipes Installation	2005	5,000		20	250	250	979	12
13	Disassemble Existing Plumbing	2005	18,465		20	923	923	3,616	13
14	Kitchen Construction	2005	403		20	20	20	77	14
15	Kitchen Construction	2005	2,192		20	110	110	420	15
16	Kitchen Construction	2005	120		20	6	6	23	16
17	Kitchen Construction	2005	178		20	9	9	33	17
18	Townsquare Board	2005	1,586		20	79	79	297	18
19	Well Leak Repair	2005	1,063		20	53	53	199	19
20	Boiler Coil Replacement	2005	3,279		20	164	164	601	20
21	Improvement	2005	227		20	11	11	41	21
22	Improvement	2005	831		20	42	42	149	22
23	Hvac Motors	2005	550		20	28	28	96	23
24	Shower Materials	2005	1,049		20	52	52	179	24
25	Carpet	2005	1,750		20	88	88	299	25
26	Water Filtration	2005	5,800		20	290	290	967	26
27	Chiller Repairs	2005	4,044		20	202	202	674	27
28	Chiller Repairs	2005	735		20	37	37	132	28
29	Chiller Repairs	2005	1,614		20	81	81	276	29
30	Removal Of Damaged Panic Bar Hardware	2005	2,014		20	101	101	327	30
31	Bypass & Chloring Meter Installation	2005	3,476		20	174	174	565	31
32	Mobile Intermediate Hydrocollator Tank	2005	1,197		20	60	60	194	32
33	Chiller Repairs	2005	800		20	40	40	130	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,089,600	\$ 344,770		\$ 192,218	\$ (152,552)	\$ 1,503,317	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:

01/01/08

Ending:

12/31/08**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,089,600	\$ 344,770		\$ 192,218	\$ (152,552)	\$ 1,503,317	1
2	Aggrecko	2005	8,812		20	441	441	1,432	2
3	Work Order	2005	621		20	31	31	101	3
4	Building Remodeling Project	2005	937		20	47	47	152	4
5	Flowmeter & Metering Pump	2005	2,228		20	111	111	362	5
6	Colonial Grids	2005	1,000		20	50	50	154	6
7	End Caps & Hand Rails	2005	10,247		20	512	512	1,580	7
8	Fire Alarm Panel Repairs	2005	853		20	43	43	131	8
9	55 Gallon Tank & Saddle Clamp	2005	1,818		20	91	91	280	9
10	Fire Alarm Panel Repairs	2005	1,406		20	70	70	217	10
11	Wallpaper	2005	1,484		20	74	74	278	11
12	Valances	2005	22,535		20	1,127	1,127	4,319	12
13	Wallpaper	2005	767		20	38	38	141	13
14	Room Signs	2005	2,216		20	111	111	425	14
15	Carpet	2005	6,011		20	301	301	1,077	15
16	Permit Application Fee	2005			20				16
17	Valances	2005	10,904		20	545	545	1,908	17
18	Blinds & Wallpaper	2005	1,091		20	55	55	191	18
19	Carpet	2005	3,011		20	151	151	540	19
20	Carpet	2005	1,060		20	53	53	181	20
21	Framing & Drywall	2005	38,500		20	1,925	1,925	6,256	21
22	Electrical Work	2005	2,171		20	109	109	344	22
23	Flooring	2005	480		20	24	24	76	23
24	Window Treatment Installation	2005	627		20	31	31	97	24
25	Repair Flooring	2005	788		20	39	39	122	25
26	Computer & Telephone Cableing	2005	1,170		20	59	59	180	26
27	Exhaust Fans, Ductwork	2005	1,175		20	59	59	181	27
28	Electrical Work	2005	3,307		20	165	165	524	28
29	Recessed Pendants	2005	3,480		20	174	174	566	29
30	Plumbing & Ceramic Tile	2005	2,026		20	101	101	329	30
31	Carpet	2005	252		20	13	13	41	31
32	Counter Top	2005	394		20	20	20	64	32
33	Framing & Drywall	2005	19,067		20	953	953	3,019	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,240,038	\$ 344,770		\$ 199,741	\$ (145,029)	\$ 1,528,585	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:

01/01/08

Ending:

12/31/08**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,240,038	\$ 344,770		\$ 199,741	\$ (145,029)	\$ 1,528,585	1
2	Wallpaper	2005	30		20	1	1	5	2
3	2 A/C Units	2005	1,161		20	58	58	198	3
4	Drywall & Supplies	2005	1,925		20	96	96	329	4
5	Improvement	2005	111		20	6	6	17	5
6	Ductwork & Sheet Metal	2005	4,010		20	201	201	652	6
7	Improvement	2005	19,800		20	990	990	3,218	7
8	Remodeling Building Supplies	2005	3,489		20	174	174	552	8
9	Handrails	2005	541		20	27	27	90	9
10	Kewanee Copr - Improvement	2005	1,050		20	53	53	171	10
11	Door & Hardware	2005	3,898		20	195	195	666	11
12	Doors	2005	2,985		20	149	149	510	12
13	Demolition, Framing, Drywall	2005	25,850		20	1,293	1,293	4,308	13
14	Carpet	2005	3,485		20	174	174	566	14
15	Improvement	2005	4,500		20	225	225	731	15
16	Floor & Wall Tile	2005	2,500		20	125	125	417	16
17	Carpet, Vinyl Base & Floor Prep	2005	445		20	22	22	72	17
18	Carpet, Vinyl Base & Floor Prep	2005	361		20	18	18	59	18
19	Wallpaper	2005	228		20	11	11	37	19
20	Electrical Work	2005	3,430		20	172	172	572	20
21	Electrical Work	2005	1,596		20	80	80	259	21
22	Door Light	2005	79		20	4	4	13	22
23	Window & Door Wire Glass	2005	100		20	5	5	16	23
24	Door Wire Glass	2005	551		20	28	28	90	24
25	Electrical Materials	2005	20		20	1	1	3	25
26	Sprinkler Plan Copies	2005			20				26
27	Wallpaper Supplies	2005	476		20	24	24	91	27
28	Vinyl Flooring	2005	6,034		20	302	302	1,157	28
29	Wallpaper & Handrails	2005	4,320		20	216	216	828	29
30	Vinyl Flooring & Wallpaper	2005	4,552		20	228	228	872	30
31	Renovation Labor	2005	5,600		20	280	280	1,050	31
32	Vinyl Flooring & Wallpaper	2005	7,729		20	386	386	1,449	32
33	Renovation Labor	2005	4,930		20	247	247	924	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,355,824	\$ 344,770		\$ 205,532	\$ (139,238)	\$ 1,548,507	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Arlington Rehab &amp; Living Center

# 0040899

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 6,355,824	\$ 344,770		\$ 205,532	\$ (139,238)	\$ 1,548,507	1
2	Renovation Labor	2005	4,000		20	200	200	733	2
3	Wallpapering	2005	3,050		20	152	152	559	3
4	Vinyl Flooring & Wallpaper	2005	7,366		20	368	368	1,320	4
5	Renovation Labor	2005	2,800		20	140	140	502	5
6	Renovation Labor	2005	4,000		20	200	200	733	6
7	Vinyl Flooring & Wallpaper	2005	2,003		20	100	100	351	7
8	Renovation Labor	2005	2,400		20	120	120	420	8
9	Renovation Labor	2005	3,600		20	180	180	630	9
10	Renovation Labor	2005	1,200		20	60	60	210	10
11	Renovation Labor	2005	5,831		20	292	292	996	11
12	Data & Telephone Cableing, Smoke Detectors	2005	1,897		20	95	95	308	12
13	Relocate Fire Alarm Strobes & Pull Stations	2005	325		20	16	16	53	13
14	Flooring	2005	4,538		20	227	227	737	14
15	Flooring	2005	780		20	39	39	127	15
16	Wallpaper & Blinds	2005	4,826		20	241	241	784	16
17	Locking Sliding Glass Window	2005	942		20	47	47	153	17
18	Wallpaper	2005	14,173		20	709	709	2,835	18
19	Wallpaper	2005	1,442		20	72	72	288	19
20	Improvements	2005	1,937		20	97	97	299	20
21	Building Addition	2005	13,150		20	4,055	4,055	4,055	21
22	Boiler Repairs	2005	1,632		20	503	503	503	22
23	Repair Therapy Room Floor	2005	4,227		20	1,339	1,339	1,339	23
24	Compressor Replacement	2006	2,522		20	126	126	326	24
25	Building Addition	2006	83,040		20	6,367	6,367	17,300	25
26	Therapy Mirrors	2006	3,611		20	361	361	812	26
27	16 Port Analog Pack	2006	3,152		20	315	315	657	27
28	Chiller	2006	44,900		20	4,490	4,490	11,973	28
29	Chiller	2006	(35,168)		20	(3,517)	(3,517)	(9,378)	29
30	Service Chiller	2006	1,626		20	163	163	434	30
31	Install Wallcoverings	2006	1,920		20	192	192	544	31
32	Electrical Work For Chiller	2006	4,926		20	493	493	1,314	32
33	Sewage Pump	2006	899		20	90	90	247	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,553,371	\$ 344,770		\$ 223,864	\$ (120,906)	\$ 1,590,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Arlington Rehab &amp; Living Center

# 0040899

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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	<b>Totals from Page 12E, Carried Forward</b>		\$ 6,553,371	\$ 344,770		\$ 223,864	\$ (120,906)	\$ 1,590,671	1
2	Remodeling - Carpet, Wallcovering	2006	11,344		20	567	567	1,182	2
3	Sprinkler Repairs/Pump Room	2007	5,301		20	530	530	972	3
4	Rebuilt Laundry Boiler	2007	3,390		20	283	283	518	4
5	New Domestic Water Treatment System	2007	13,178		20	1,318	1,318	2,086	5
6	Restore Unit Electronic Door	2007	2,363		20	236	236	335	6
7	Lobby Remodeling & Flooring	2007	3,413		20	341	341	626	7
8	Office & Copy Room Remodeling	2007	3,120		20	312	312	442	8
9	Flooring	2007	41,469		20	1,901	1,901	2,246	9
10	Carpet	2007	3,254		20	149	149	176	10
11	Bedroom Flooring	2007	11,800		20	541	541	639	11
12	Storage & Dining Buildout	2007	3,512		20	176	176	351	12
13	Dining, Therapy, Office Buildout	2007	10,433		20	522	522	1,000	13
14	Sprinkler System - Replace Piping	2007	14,116		20	706	706	1,235	14
15	Fin Frame & Screen	2007	3,430		20	172	172	257	15
16	Deck, Structural Installation, Anchor Bolts, Set Plates	2007	144,688		20	7,234	7,234	9,646	16
17	Plastering & Repairs	2007	2,650		20	133	133	177	17
18	Fencing & Night Light Fixtures	2007	10,337		20	517	517	689	18
19	Paint Steel Balconies	2007	5,700		20	285	285	356	19
20	Bathfloor Tiles	2007	14,699		20	735	735	919	20
21	Landscaping Level Ground, Top Soil	2007	5,000		20	250	250	292	21
22	Hvac Unit	2007	7,926		20	396	396	462	22
23	Roof Replacement	2007	22,950		20	1,148	1,148	1,243	23
24	Curtains, End Caps, Splices	2007	4,525		20	226	226	245	24
25	Framing & Drywall, Insulations, Access Panels	2007	134,700		20	6,735	6,735	7,296	25
26	Sliding Door Tracks, Shower Receptors	2007	21,153		20	1,058	1,058	1,146	26
27	Steel Work	2007	4,580		20	229	229	363	27
28	Shower Area Radiant Piping / Concrete Prep	2007	5,510		20	276	276	413	28
29	Barricades, Windows, Shower Bases, Patch Holes	2007	7,430		20	372	372	526	29
30	Brick Walls, Ceramic Tiling, Insulation, Caulking	2007	14,211		20	711	711	829	30
31	Fence*	2008	2,239		20	28	28	28	31
32	New Unit Drapery*	2008	8,156		20	408	408	408	32
33	Awning For Restore Unit*	2008	1,327		20	28	28	28	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,101,275	\$ 344,770		\$ 252,387	\$ (92,383)	\$ 1,627,802	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:

01/01/08

Ending:

12/31/08**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	<b>Totals from Page 12F, Carried Forward</b>		\$ 7,101,275	\$ 344,770		\$ 252,387	\$ (92,383)	\$ 1,627,802	1
2	New Phone System*	2008	21,103		20	616	616	616	2
3	Wall Coverings - New Unit*	2008	6,763		20	310	310	310	3
4	Resurface Parking Lot*	2008	43,650		20	728	728	728	4
5	Plumbing*	2008	9,274		20	232	232	232	5
6	Flooring	2008	5,343		20	89	89	89	6
7	Flooring	2008	27,646		20	1,152	1,152	1,152	7
8	Flooring	2008	27,646		20	1,152	1,152	1,152	8
9	Flooring	2008	27,646		20	1,037	1,037	1,037	9
10	Flooring	2008	17,898		20	671	671	671	10
11	Flooring	2008	16,129		20	538	538	538	11
12	Flooring	2008	5,376		20	134	134	134	12
13	Carpet	2008	2,797		20	105	105	105	13
14	Carpet	2008	4,813		20	160	160	160	14
15	Carpet	2008	3,534		20	147	147	147	15
16	Carpet	2008	2,799		20	117	117	117	16
17	Service Outside Lights	2008	5,997		20	100	100	100	17
18	Flooring & Installation	2008	50,000		20	2,083	2,083	2,083	18
19	Repair Fixture Sockets	2008	2,611		20	33	33	33	19
20	Remodeling - Transfer Fan	2008	4,080		20	34	34	34	20
21	Repair Basement, Dish Room, Kitchen , Door, Security Devices	2008	4,208		20	88	88	88	21
22	Electrical Work	2008	7,412		20	185	185	185	22
23	Flooring, Laundry & Dining Room Repairs	2008	10,103		20	84	84	84	23
24	Painting, Stain, Door & Frames	2008	13,174		20	494	494	494	24
25	Flooring	2008	15,674		20	522	522	522	25
26	Floor Repair & Clinical Service Sink	2008	18,515		20	694	694	694	26
27	Flooring & Carpet	2008	19,036		20	635	635	635	27
28	Demolition, Drywall, Paint	2008	28,704		20	957	957	957	28
29	Repair E.I.F.S.	2008	9,600		20	280	280	280	29
30	Underground Well System Repair	2008	2,800		20	82	82	82	30
31	Bathroom Flooring	2008	6,476		20	135	135	135	31
32	Floor Installation	2008	7,484		20	187	187	187	32
33	Ceiling Tile, Shelving, Painting	2008	10,915		20	455	455	455	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,540,481	\$ 344,770		\$ 266,623	\$ (78,147)	\$ 1,642,038	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:

01/01/08

Ending:

12/31/08**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	<b>Totals from Page 12G, Carried Forward</b>		\$ 7,540,481	\$ 344,770		\$ 266,623	\$ (78,147)	\$ 1,642,038	1
2	Flooring & Carpet	2008	3,516		20	147	147	147	2
3	Bedroom Floor & Wall Base	2008	17,071		20	711	711	711	3
4	Therapy Room Flooring	2008	7,904		20	329	329	329	4
5	Bedroom Flooring	2008	20,359		20	848	848	848	5
6	Bedroom Flooring	2008	21,644		20	812	812	812	6
7	Lobby & Dining Room Flooring	2008	9,255		20	347	347	347	7
8	Flooring	2008	3,303		20	41	41	41	8
9	Flooring	2008	11,895		20	347	347	347	9
10	Plumbing - Dishwashing Room	2008	3,314		20	69	69	69	10
11	Bathroom Flooring	2008	3,670		20	76	76	76	11
12	Flooring	2008	6,166		20	231	231	231	12
13	Flooring	2008	17,855		20	670	670	670	13
14	Toilets	2008	25,768		20	537	537	537	14
15	Carpet	2008	2,817		20	94	94	94	15
16	Doors & Frames, Hager Strip, Power Supply, Keypads, Hinges	2008	30,425		20	1,521	1,521	1,521	16
17	Insulate Fore Access Panel, Door	2008	2,823		20	141	141	141	17
18	Data & Cable Wiring, Termination, Testing	2008	4,560		20	228	228	228	18
19	Ceiling Grid, Painting Walls, Ceilings, Doors	2008	35,360		20	1,768	1,768	1,768	19
20	Excavation & Concrete, Grading Walls, Strip Dirt, Trench For Foo	2008	184,788		20	9,239	9,239	9,239	20
21	Tile Base And Bath Floor Tiles	2008	11,037		20	552	552	552	21
22	Flooring, Ceramic Tiles, Carpeting	2008	10,884		20	499	499	499	22
23	Carpeting	2008	5,477		20	251	251	251	23
24	Sprinklers, Remodel Bathroom, Repairs	2008	50,933		20	2,334	2,334	2,334	24
25	Piping System Installation	2008	168,690		20	7,732	7,732	7,732	25
26	Doors, Showers, Bathroom, Curtains	2008	42,165		20	1,933	1,933	1,933	26
27	Hallway & Dining Room Wallpaper	2008	5,275		20	242	242	242	27
28	Radiant Heating	2008	110,295		20	5,055	5,055	5,055	28
29	Electrical Work, Lighting, Alarm	2008	288,122		20	14,406	14,406	14,406	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	1
2									2
3									3
4									4
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6									6
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12I, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	1
2									2
3									3
4									4
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30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12J, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12K, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	1
2									2
3									3
4									4
5									5
6									6
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8									8
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12L, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	1
2									2
3									3
4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

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**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12M, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	1
2									2
3									3
4									4
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12N, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12O, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12P, Carried Forward</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,645,852	\$ 344,770		\$ 317,783	\$ (26,987)	\$ 1,693,198	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:

01/01/08

Ending:

12/31/08

**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	\$ 13,067	4
5			1995	1995	5,614,638	75,743	35	160,418	84,675	1,283,345	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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:

01/01/08

Ending:

12/31/08

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	5,634,743	\$	75,743	\$	161,423	\$	85,680	\$	1,296,412	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

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

01/01/08

Ending:

12/31/08

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	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: 01/01/08 Ending: 12/31/08

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	\$ 489,235	\$	\$ 59,408	\$ 59,408	10	\$ 273,917	71
72	Current Year Purchases	192,816		11,446	11,446	10	11,446	72
73	Fully Depreciated Assets	455,776				10	455,776	73
74								74
75	TOTALS	\$ 1,137,827	\$	\$ 70,854	\$ 70,854		\$ 741,139	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	62,720	77
78		FORD F150 TRUCK	2008	25,900		863	863	5	863	78
79										79
80	TOTALS			\$ 116,620	\$	\$ 7,465	\$ 7,465		\$ 88,281	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)		\$ 10,072,491	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 344,770	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 396,102	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 51,332	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,522,618	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	<b>TOTAL</b>				\$			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 13,439 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	<b>TOTAL</b>		\$	\$	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 396,452	\$		\$ 396,452	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			157,113			157,113	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			495,477			495,477	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				262,921		262,921	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					57,891	46,697		104,588	13
14	TOTAL			\$		\$ 1,106,933	\$ 309,618		\$ 1,416,551	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: 01/01/08

Ending:

12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,787	\$ 19,699	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,555,477	2,555,477	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,818	62,818	6
7	Other Prepaid Expenses	33,442	33,442	7
8	Accounts Receivable (owners or related parties)	476,911	476,911	8
9	Other(specify): <u>See Attached Schedule</u>	239,660	239,660	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,371,595	\$ 3,388,507	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		94,987	13
14	Buildings, at Historical Cost		3,191,252	14
15	Leasehold Improvements, at Historical Cost	989,383	989,383	15
16	Equipment, at Historical Cost	1,187,204	1,187,204	16
17	Accumulated Depreciation (book methods)	(1,505,319)	(1,830,248)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 679,209	\$ 3,640,519	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,050,804	\$ 7,029,026	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,116,781	\$ 1,116,781	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,709,533	1,709,533	29
30	Accrued Salaries Payable	352,362	352,362	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,997	38,997	31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,055	112,055	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	302,956	3,029,730	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,632,684	\$ 6,359,458	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,778,866	2,778,866	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,778,866	\$ 2,778,866	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,411,550	\$ 9,138,324	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,360,746)	\$ (2,109,298)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,050,804	\$ 7,029,026	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,577,141)	1
2	Restatements (describe):		2
3	Late Journal Entries	1,461,356	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (115,785)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(416,961)	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	(1,828,000)	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)	\$ (2,244,961)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,360,746)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,719,491	1
2	Discounts and Allowances for all Levels	410,228	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,129,719</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,790,868	6
7	Oxygen	24,630	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,815,498</b>	8
<b>C. Other Operating Revenue</b>			
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	299,437	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,534	19
20	Radiology and X-Ray	5,232	20
21	Other Medical Services	49,036	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 374,239</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	283	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 283</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,263	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,263</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 11,321,002</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,255,115	31
32	Health Care	4,112,363	32
33	General Administration	2,104,107	33
<b>B. Capital Expense</b>			
34	Ownership	1,667,008	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,495,060	35
36	Provider Participation Fee	104,310	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,737,963</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(416,961)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (416,961)</b>	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: 01/01/08

Ending:

12/31/08

**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	944	1,016	\$ 40,586	\$ 39.95	1
2	Assistant Director of Nursing	120	120	4,327	36.06	2
3	Registered Nurses	28,963	31,144	963,593	30.94	3
4	Licensed Practical Nurses	32,395	34,556	998,323	28.89	4
5	CNAs & Orderlies	95,252	101,021	1,404,316	13.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,291	6,919	118,441	17.12	8
9	Activity Director	1,832	1,920	36,509	19.02	9
10	Activity Assistants	9,460	9,991	98,181	9.83	10
11	Social Service Workers	7,233	7,855	167,145	21.28	11
12	Dietician	1,529	1,786	49,850	27.91	12
13	Food Service Supervisor					13
14	Head Cook	7,124	7,989	122,933	15.39	14
15	Cook Helpers/Assistants	21,351	22,552	221,071	9.80	15
16	Dishwashers					16
17	Maintenance Workers	3,566	3,922	47,654	12.15	17
18	Housekeepers	31,108	32,787	322,750	9.84	18
19	Laundry	3,740	3,953	37,562	9.50	19
20	Administrator	1,992	2,160	118,279	54.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,927	28,585	438,772	15.35	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	1,758	1,989	41,338	20.78	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,080	2,080	76,937	36.99	33
34	TOTAL (lines 1 - 33)	282,665	302,345	\$ 5,308,567 *	\$ 17.56	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	418	\$ 18,083	01-03	35
36	Medical Director	Monthly	28,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	141	7,728	10-03	38
39	Pharmacist Consultant	Monthly	678	10-03	39
40	Physical Therapy Consultant	4	226	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	210	10a-03	43
44	Activity Consultant	99	5,582	11-03	44
45	Social Service Consultant	80	5,963	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	745	\$ 66,970		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,563	\$ 4,563	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,563	\$ 4,563		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

# 0040899

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	0	\$ 112,848	Workers' Compensation Insurance	\$ 132,217	IDPH License Fee	\$			
Theodore O'Brien	Administrator	0	5,432	Unemployment Compensation Insurance	39,658	Advertising: Employee Recruitment	26,015			
				FICA Taxes	366,999	Health Care Worker Background Check	1,467			
				Employee Health Insurance	135,287	(Indicate # of checks performed <u>136</u> )				
				Employee Meals	21,960	Patient Background Checks <u>237</u>	2,550			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,079			
				401K Matching Expense	22,347	Dues - ICLTC	6,905			
				Other Employee Benefits	32,642	Licenses Inspection & Fees	6,887			
TOTAL (agree to Schedule V, line 17, col. 1)										
(List each licensed administrator separately.)			\$ 118,279							
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	\$ 39,196						Out-of-State Travel	\$		
Senior Living Consultants - Management Fees	61,022									
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 100,218	TOTAL (agree to Schedule V, line 22, col.8)			\$ 751,109	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 45,903
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount		
FR&R	Accounting	\$ 35,795					Out-of-State Travel	\$		
Camille Koehl	Accounting	1,090								
Personnel Planners	Unemployment Consulting	1,345					In-State Travel			
See Attached	Legal	170,893								
Equinox	Computer Services	119					Seminar Expense	8,564		
ADI	Computer Services	568								
American Data	Computer Services	4,378								
CDW	Computer Services	22,697					Entertainment Expense	( )		
Computerized Business	Computer Services	1,398					(agree to Sch. V, line 24, col. 8)			
HDS	Computer Services	7,126								
Digital Power Products	Computer Services	68								
See Supplemental Schedule		5,464								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 8,564
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 250,941							

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Arlington Rehab & Living Center

Report Period Beginning: 01/01/08 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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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 - \$13,720
- (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. \$ 57,853 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 104,310  
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. \$ 21,960 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? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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