

Facility Name & ID Number Arlington Rehab & Living Center

0040899 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	190	Skilled (SNF)	190	69,350	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	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	44,333	6,524	14,580	65,437	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,333	6,524	14,580	65,437	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.36%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1/2/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/2/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 190 and days of care provided 10,503

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	425,257	54,390	10,067	489,714		489,714		489,714		1
2	Food Purchase		341,633		341,633	(23,652)	317,981	(340)	317,641		2
3	Housekeeping	286,788	56,827		343,615		343,615		343,615		3
4	Laundry	74,819	27,246		102,065		102,065		102,065		4
5	Heat and Other Utilities			156,194	156,194		156,194	(12,452)	143,742		5
6	Maintenance	63,235	105,693	722,018	890,946		890,946	(559,625)	331,321		6
7	Other (specify):*										7
8	TOTAL General Services	850,099	585,789	888,279	2,324,167	(23,652)	2,300,515	(572,417)	1,728,098		8
	B. Health Care and Programs										
9	Medical Director			41,400	41,400		41,400		41,400		9
10	Nursing and Medical Records	3,781,887	199,368	11,696	3,992,951		3,992,951	(7,785)	3,985,166		10
10a	Therapy	144,491	3,083	331	147,905		147,905	(114)	147,791		10a
11	Activities	192,866	9,437	4,999	207,302		207,302		207,302		11
12	Social Services	190,406		3,422	193,828		193,828		193,828		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,309,650	211,888	61,848	4,583,386		4,583,386	(7,899)	4,575,487		16
	C. General Administration										
17	Administrative	202,313			202,313		202,313		202,313		17
18	Directors Fees										18
19	Professional Services			175,114	175,114	(8,009)	167,105	(11,647)	155,458		19
20	Dues, Fees, Subscriptions & Promotions			94,936	94,936		94,936	(48,489)	46,447		20
21	Clerical & General Office Expenses	354,387	11,215	1,391,982	1,757,584		1,757,584	(1,248,142)	509,442		21
22	Employee Benefits & Payroll Taxes			883,617	883,617	23,652	907,269		907,269		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,105	9,105		9,105	(1,369)	7,736		24
25	Other Admin. Staff Transportation			28,913	28,913		28,913	(5,820)	23,093		25
26	Insurance-Prop.Liab.Malpractice			521,274	521,274		521,274		521,274		26
27	Other (specify):*										27
28	TOTAL General Administration	556,700	11,215	3,104,941	3,672,856	15,643	3,688,499	(1,315,467)	2,373,032		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,716,449	808,892	4,055,068	10,580,409	(8,009)	10,572,400	(1,895,783)	8,676,617		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arlington Rehab & Living Center

#0040899

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			182,992	182,992		182,992	277,993	460,985			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			247,568	247,568		247,568	(243,718)	3,850			32
33	Real Estate Taxes			132,529	132,529	8,009	140,538		140,538			33
34	Rent-Facility & Grounds			1,114,296	1,114,296		1,114,296	(1,114,296)				34
35	Rent-Equipment & Vehicles			19,422	19,422		19,422	(7,116)	12,306			35
36	Other (specify):*											36
37	TOTAL Ownership			1,696,807	1,696,807	8,009	1,704,816	(1,087,137)	617,679			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		376,698	1,488,014	1,864,712		1,864,712	(171,109)	1,693,603			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	13,773		16,194	29,967		29,967	(12,913)	17,054			41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*	110,224			110,224		110,224	(110,224)				43
44	TOTAL Special Cost Centers	123,997	376,698	1,608,233	2,108,928		2,108,928	(294,246)	1,814,682			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,840,446	1,185,590	7,360,108	14,386,144		14,386,144	(3,277,166)	11,108,978			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

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	(12,452)	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	161,947	30		9
10	Interest and Other Investment Income	(10,010)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(340)	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	(44,850)	21		18
19	Entertainment	(7,754)	21		19
20	Contributions	(350)	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	(1,160,643)	21		24
25	Fund Raising, Advertising and Promotional	(48,139)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,177,577)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,300,168)		\$	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)	(976,998)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (976,998)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,277,166)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Arlington Rehab & Living Center

ID# 0040899

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Capitalized R&M	\$ (559,625)	06	1
2	Misc Income - Theft Loss Recovery	(117)	21	2
3	Misc Income - Jury Duty Income	(34)	10	3
4	Misc Income - Medical Records Income	(440)	10	4
5	Patient Needs	(7,311)	10	5
6	Bistro Income	(12,913)	41	6
7	Marketing Wages	(110,224)	43	7
8	Bank Charges	(8,884)	21	8
9	Franchise Tax	(2,851)	21	9
10	Building Company - Bank Charges	(658)	21	10
11	Building Company - Legal & Accounting	(8,637)	19	11
12	Building Company - Management Fees	(33,784)	19	12
13	Building Company - Taxes	(11,548)	21	13
14	Building Company - Misc. Expense	(353)	21	14
15	Non-Allowable Interest Expense	(371,203)	32	15
16	Non-Allowable Auto Lease	(7,116)	35	16
17	Non-Allowable Seminar Expense	(1,369)	24	17
18	Non-Allowable Legal Fees	(4,212)	19	18
19	Non-Allowable Auto Expense	(5,820)	25	19
20	Capitalized Professional Fees - Architect	(7,435)	19	20
21	Non-Allowable Expense	(23,043)	21	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,177,577)		49

Arlington Rehab & Living Center

ID# 0040899

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(340)											(340)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,452)											(12,452)	5
6	Maintenance	(559,625)											(559,625)	6
7	Other (specify):*													7
8	TOTAL General Services	(572,417)											(572,417)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(7,785)											(7,785)	10
10a	Therapy			(114)									(114)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(7,785)		(114)									(7,899)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(54,068)	42,421										(11,647)	19
20	Fees, Subscriptions & Promotions	(48,489)											(48,489)	20
21	Clerical & General Office Expenses	(1,260,701)	12,559										(1,248,142)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,369)											(1,369)	24
25	Other Admin. Staff Transportation	(5,820)											(5,820)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(1,370,447)	54,980										(1,315,467)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,950,649)	54,980	(114)									(1,895,783)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	161,947	116,046										277,993	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(381,213)	137,495										(243,718)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,114,296)										(1,114,296)	34
35	Rent-Equipment & Vehicles	(7,116)											(7,116)	35
36	Other (specify):*													36
37	TOTAL Ownership	(226,382)	(860,755)										(1,087,137)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(171,109)									(171,109)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(12,913)											(12,913)	41
42	Provider Participation Fee													42
43	Other (specify):*	(110,224)											(110,224)	43
44	TOTAL Special Cost Centers	(123,137)		(171,109)									(294,246)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,300,168)	(805,775)	(171,223)									(3,277,166)	45

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		Auror Rehabilitation Center	Aurora, IL	Kedzie Home	Chicago, IL	Building 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,114,296	Kedzie Home LLC	100.00%	\$	\$ (1,114,296)	1
2	V	30 Depreciation		Kedzie Home LLC		116,046	116,046	2
3	V	32 Interest Expense		Kedzie Home LLC		137,495	137,495	3
4	V	21 Bank Charges		Kedzie Home LLC		658	658	4
5	V	19 Legal & Accounting		Kedzie Home LLC		8,637	8,637	5
6	V	19 Management Fees		Kedzie Home LLC		33,784	33,784	6
7	V	21 Taxes - Franchise & State		Kedzie Home LLC		11,548	11,548	7
8	V	21 Misc. Expense		Kedzie Home LLC		353	353	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,114,296			\$ 308,521	\$ * (805,775)	14

* 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	39 Ancillary Rehab	\$ 1,394,032	Simply Rehab	100.00%	\$ 1,222,923	\$ (171,109)
16	V	10a Rehab Consulting	933	Simply Rehab	100.00%	819	(114)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,394,965			\$ 1,223,742	\$ * (171,223)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	Aaron Mann	Director Operations	Administrative	0	See Attached	20.00	50.00%	Salary	\$ 97,500	17-01	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 97,500		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Rehab	Direct Allocation					1,222,923	1
2	10a	Ancillary Rehab	Direct Allocation					819	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$	\$	\$ 1,223,742	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5	See Supplemental Schedule																		
Working Capital																			
6	First Bank		X	Line of Credit				177,414		13,860	6								
7	Shareholder Loans	X		Working Capital				2,741,694		110,479	7								
8	See Supplemental Schedule																		
9	TOTAL Facility Related						\$	\$ 7,751,311		\$ 13,860	9								
B. Non-Facility Related*																			
10	Interest Income																		
11										(10,010)	10								
11											11								
12											12								
13	See Supplemental Schedule																		
14	TOTAL Non-Facility Related						\$	\$		\$ (10,010)	14								
15	TOTALS (line 9+line14)						\$	\$ 7,751,311		\$ 3,850	15								

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

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

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:

01/01/09

Ending:

12/31/09

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

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8	Venture Fund	X		Working Capital			\$	\$ 2,185,523			\$ 123,229	8							
9	Venture Fund (Bldg Co)	X		Working Capital				2,646,680			137,495	9							
10	Adjusted on page 5																		
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related																		

* 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:

01/01/09

Ending:

12/31/09

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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1996		31,575		20	1,515	1,515	21,886	9
10	Various		1997		34,251		20	1,712	1,712	19,239	10
11	Various		1998		115,118		20	5,755	5,755	65,314	11
12	Various		1999		8,794		20	439	439	4,190	12
13	Various		2000		5,943		20	553	553	5,430	13
14	Various		2001		11,296		20	566	566	4,828	14
15	Various		2002		41,668		20	4,167	4,167	30,696	15
16	Various		2003		12,640		20	1,264	1,264	7,964	16
17	Various		2004		102,912		20	10,290	10,290	56,750	17
18	Various		2005		443,003		20	23,104	23,104	103,096	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:

01/01/09

Ending:

12/31/09

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		7,034,743	116,046		201,423	85,377	1,497,835	67
68								68
69			182,992			(182,992)		69
70		\$ 7,841,943	\$ 299,038		\$ 250,788	\$ (48,250)	\$ 1,817,228	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:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,841,943	\$ 299,038		\$ 250,788	\$ (48,250)	\$ 1,817,228	1
2	Compressor Replacement	2006	2,522		20	126	126	452	2
3	Building Addition	2006	83,040		20	8,304	8,304	25,604	3
4	Therapy Mirrirs	2006	3,611		20	361	361	1,174	4
5	16 Port Analog Pack	2006	3,152		20	315	315	972	5
6	Chiller	2006	44,900		20	4,490	4,490	16,463	6
7	Chiller	2006	(35,168)		20	(3,517)	(3,517)	(12,895)	7
8	Service Chiller	2006	1,626		20	163	163	596	8
9	Install Wallcoverings	2006	1,920		20	192	192	736	9
10	Electrical Work For Chiller	2006	4,926		20	493	493	1,806	10
11	Sewage Pump	2006	899		20	90	90	337	11
12	Remodeling - Carpet, Wallcovering	2006	11,344		20	567	567	1,749	12
13	Sprinkler Repairs/Pump Room	2007	5,301		20	530	530	1,502	13
14	Rebuilt Laundry Boiler	2007	3,390		20	283	283	800	14
15	New Domestic Water Tretment System	2007	13,178		20	1,318	1,318	3,404	15
16	Restore Unit Electronic Door	2007	2,363		20	236	236	571	16
17	Lobby Remodeling & Flooring	2007	3,413		20	341	341	967	17
18	Office & Copy Room Remodeling	2007	3,120		20	312	312	754	18
19	Flooring	2007	41,469		20	2,073	2,073	4,320	19
20	Carpet	2007	3,254		20	163	163	339	20
21	Bedroom Flooring	2007	11,800		20	590	590	1,229	21
22	Storage & Dining Buildout	2007	3,512		20	176	176	527	22
23	Dining, Therapy, Office Buildout	2007	10,433		20	522	522	1,521	23
24	Sprinkler System - Replace Piping	2007	14,116		20	706	706	1,941	24
25	Fin Frame & Screen	2007	3,430		20	172	172	429	25
26	Deck, Structural Installation, Anchor Bolts, Set Plates	2007	144,688		20	7,234	7,234	16,880	26
27	Plastering & Repairs	2007	2,650		20	133	133	309	27
28	Fencing & Night Light Fixtures	2007	10,337		20	517	517	1,206	28
29	Paint Steel Balconies	2007	5,700		20	285	285	641	29
30	Bathfloor Tiles	2007	14,699		20	735	735	1,654	30
31	Landscaping Level Ground, Top Soil	2007	5,000		20	250	250	542	31
32	Hvac Unit	2007	7,926		20	396	396	859	32
33	Roof Replacement	2007	22,950		20	1,148	1,148	2,391	33
34	TOTAL (lines 1 thru 33)		\$ 8,297,444	\$ 299,038		\$ 280,492	\$ (18,546)	\$ 1,897,008	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:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,297,444	\$ 299,038		\$ 280,492	\$ (18,546)	\$ 1,897,008	1
2	Curtains, End Caps, Splices	2007	4,525		20	226	226	471	2
3	Framing & Drywall, Insulations, Access Panels	2007	134,700		20	6,735	6,735	14,031	3
4	Sliding Door Tracks, Shower Receptors	2007	21,153		20	1,058	1,058	2,203	4
5	Steel Work	2007	4,580		20	229	229	592	5
6	Shower Area Radiant Piping / Concrete Prep	2007	5,510		20	276	276	689	6
7	Barricades, Windows, Shower Bases, Patch Holes	2007	7,430		20	372	372	898	7
8	Brick Walls, Ceramic Tiling, Insulation, Caulking	2007	14,211		20	711	711	1,540	8
9	Fence	2008	2,239		20	112	112	140	9
10	New Unit Drapery	2008	8,156		20	408	408	816	10
11	Awning For Restore Unit	2008	1,327		20	66	66	94	11
12	New Phone System	2008	21,103		20	1,055	1,055	1,671	12
13	Wall Coverings - New Unit	2008	6,763		20	338	338	648	13
14	Resurface Parking Lot	2008	43,650		20	2,183	2,183	2,910	14
15	Plumbing	2008	9,274		20	464	464	696	15
16	Flooring	2008	5,343		20	267	267	356	16
17	Flooring	2008	27,646		20	1,382	1,382	2,534	17
18	Flooring	2008	27,646		20	1,382	1,382	2,534	18
19	Flooring	2008	27,646		20	1,382	1,382	2,419	19
20	Flooring	2008	17,898		20	895	895	1,566	20
21	Flooring	2008	16,129		20	806	806	1,344	21
22	Flooring	2008	5,376		20	269	269	403	22
23	Carpet	2008	2,797		20	140	140	245	23
24	Carpet	2008	4,813		20	241	241	401	24
25	Carpet	2008	3,534		20	177	177	324	25
26	Carpet	2008	2,799		20	140	140	257	26
27	Service Outside Lights	2008	5,997		20	300	300	400	27
28	Flooring & Installation	2008	50,000		20	2,500	2,500	4,583	28
29	Repair Fixture Sockets	2008	2,611		20	131	131	163	29
30	Remodeling - Transfer Fan	2008	4,080		20	204	204	238	30
31	Repair Basement, Dish Room, Kitchen , Door, Security Devices	2008	4,208		20	210	210	298	31
32	Electrical Work	2008	7,412		20	371	371	556	32
33	Flooring, Laundry & Dining Room Repairs	2008	10,103		20	505	505	589	33
34	TOTAL (lines 1 thru 33)		\$ 8,808,103	\$ 299,038		\$ 306,027	\$ 6,989	\$ 1,943,617	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:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,808,103	\$ 299,038		\$ 306,027	\$ 6,989	\$ 1,943,617	1
2	Painting, Stain, Door & Frames	2008	13,174		20	659	659	1,153	2
3	Flooring	2008	15,674		20	784	784	1,306	3
4	Floor Repair & Clinical Service Sink	2008	18,515		20	926	926	1,620	4
5	Flooring & Carpet	2008	19,036		20	952	952	1,586	5
6	Demolition, Drywall, Paint	2008	28,704		20	1,435	1,435	2,392	6
7	Repair E.I.F.S.	2008	9,600		20	480	480	760	7
8	Underground Well System Repair	2008	2,800		20	140	140	222	8
9	Bathroom Flooring	2008	6,476		20	324	324	459	9
10	Floor Installation	2008	7,484		20	374	374	561	10
11	Ceiling Tile, Shelving, Painting	2008	10,915		20	546	546	1,001	11
12	Flooring & Carpet	2008	3,516		20	176	176	322	12
13	Bedroom Floor & Wall Base	2008	17,071		20	854	854	1,565	13
14	Therapy Room Flooring	2008	7,904		20	395	395	725	14
15	Bedroom Flooring	2008	20,359		20	1,018	1,018	1,866	15
16	Bedroom Flooring	2008	21,644		20	1,082	1,082	1,894	16
17	Lobby & Dining Room Flooring	2008	9,255		20	463	463	810	17
18	Flooring	2008	3,303		20	165	165	206	18
19	Flooring	2008	11,895		20	595	595	942	19
20	Plumbing - Dishwashing Room	2008	3,314		20	166	166	235	20
21	Bathroom Flooring	2008	3,670		20	184	184	260	21
22	Flooring	2008	6,166		20	308	308	540	22
23	Flooring	2008	17,855		20	893	893	1,562	23
24	Toilets	2008	25,768		20	1,288	1,288	1,825	24
25	Carpet	2008	2,817		20	141	141	235	25
26	Doors & Frames, Hager Strip, Power Supply, Keypads, Hinges	2008	30,425		20	1,521	1,521	3,043	26
27	Insulate Fore Access Panel, Door	2008	2,823		20	141	141	282	27
28	Data & Cable Wiring, Termination, Testing	2008	4,560		20	228	228	456	28
29	Ceiling Grid, Painting Walls, Ceilings, Doors	2008	35,360		20	1,768	1,768	3,536	29
30	Excavation & Concrete, Grading Walls, Strip Dirt, Trench For Fo	2008	184,788		20	9,239	9,239	18,479	30
31	Tile Base And Bath Floor Tiles	2008	11,037		20	552	552	1,104	31
32	Flooring, Ceramic Tiles, Carpeting	2008	10,884		20	544	544	1,043	32
33	Carpeting	2008	5,477		20	274	274	525	33
34	TOTAL (lines 1 thru 33)		\$ 9,380,372	\$ 299,038		\$ 334,642	\$ 35,604	\$ 1,996,132	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:

01/01/09

Ending:

12/31/09**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 9,380,372	\$ 299,038		\$ 334,642	\$ 35,604	\$ 1,996,132	1
2	<u>Sprinklers-Piping, Valves, Trim, Repairs For Tie-Ins, Certification</u>	2008	50,933		20	2,547	2,547	4,881	2
3	<u>Piping System Installation</u>	2008	168,690		20	8,435	8,435	16,166	3
4	<u>Doors, Showers, Bathroom, Curtains</u>	2008	42,165		20	2,108	2,108	4,041	4
5	<u>Hallway & Dining Room Wallpaper</u>	2008	5,275		20	264	264	506	5
6	<u>Radiant Heating</u>	2008	110,295		20	5,515	5,515	10,570	6
7	<u>Electrical Work, Lighting, Alarm</u>	2008	288,122		20	14,406	14,406	28,812	7
8	<u>Remodeling - Carpet Fire Treatment</u>	2008	5,177		20	259	259	280	8
9	<u>Base Boards</u>	2009	13,807		20	403	403	403	9
10	<u>Railings</u>	2009	17,901		20	522	522	522	10
11	<u>Base Boards</u>	2009	7,789		20	227	227	227	11
12	<u>Wallcovering</u>	2009	23,908		20	1,096	1,096	1,096	12
13	<u>Flooring</u>	2009	6,720		20	308	308	308	13
14	<u>Countertops</u>	2009	13,613		20	624	624	624	14
15	<u>Nurses Station Remodel</u>	2009	2,999		20	125	125	125	15
16	<u>Brickwork</u>	2009	2,528		20	95	95	95	16
17	<u>Steel Beams</u>	2009	2,388		20	109	109	109	17
18	<u>Relocated Bathroom</u>	2009	5,725		20	239	239	239	18
19	<u>Lobby Remodel - Architect Services</u>	2009	6,449		20	296	296	296	19
20	<u>Remodel Work - Walls & Flooring</u>	2009	21,552		20	898	898	898	20
21	<u>Remodel Work - Painting & Plaster Work</u>	2009	6,620		20	303	303	303	21
22	<u>Therapy Remodel - Demolish Office, Rebuilt Framing</u>	2009	5,040		20	231	231	231	22
23	<u>Electrical Work</u>	2009	3,433		20	157	157	157	23
24	<u>Coordination Of Remodeling, Water System Corrections</u>	2009	10,174		20	466	466	466	24
25	<u>Flooring & Walls</u>	2009	7,700		20	385	385	385	25
26	<u>Remodel Work - Relocate Piping</u>	2009	6,560		20	246	246	246	26
27	<u>Remodel Bistro - Insulation</u>	2009	8,925		20	260	260	260	27
28	<u>Remodeling - Floors, Wall Cover, Handrails</u>	2009	11,650		20	437	437	437	28
29	<u>Remodeling - Walls & Floors</u>	2009	12,526		20	470	470	470	29
30	<u>Remodel Work In Bathroom, Kitchen And Salon</u>	2009	22,773		20	759	759	759	30
31	<u>Remodeling - Floors & Handrails</u>	2009	23,874		20	696	696	696	31
32	<u>Remodeling - Walls</u>	2009	10,033		20	167	167	167	32
33	<u>Bathroom Remodel - Wall/Floor Tiles, Paint, Light Fixtures</u>	2009	18,385		20	153	153	153	33
34	TOTAL (lines 1 thru 33)		\$ 10,324,101	\$ 299,038		\$ 377,848	\$ 78,810	\$ 2,071,060	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		10,324,101	299,038		377,848	78,810	2,071,060	1
2	Bathroom Remodel - Wall/Floor Tiles, Paint	2009	30,950		20	258	258	258	2
3	Remodeling - Floors	2009	3,650		20	30	30	30	3
4	Therapy Room Remodel - Floors, Walls, Ceiling	2009	6,288		20	236	236	236	4
5	Walls, Flooring, Painting	2009	11,580		20	386	386	386	5
6	Painted Mural	2009	1,045		20	39	39	39	6
7	Bistro - Granite Countertops & Backsplash	2009	3,595		20	120	120	120	7
8	Electrical Work For Remodeling	2009	23,923		20	997	997	997	8
9	Electrical Work For Remodeling	2009	12,478		20	312	312	312	9
10	Remodeling - Floors, Painting, Plumbing	2009	34,209		20	1,283	1,283	1,283	10
11	Remodeling - Floors, Painting, Plumbing	2009	34,723		20	1,013	1,013	1,013	11
12	Sprinkler Work	2009	8,460		20	282	282	282	12
13	Architect Fees - Remodeling	2009	7,435		20	372	372	372	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			10,502,437	299,038		383,176	84,138	2,076,388	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3		1996	20,105		35	1,005	1,005	14,072	3
4		1995	5,614,638		35	160,418	160,418	1,443,763	4
5	East Addition	2008	1,400,000		35	40,000	40,000	40,000	5
6	Building Company Book Depreciation			116,046			(116,046)		6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 7,034,743	\$ 116,046		\$ 201,423	\$ 85,377	\$ 1,497,835	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Related Party Information		\$	\$		\$	\$	\$
2 Buildings:							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
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17							
18							
19							
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26							
27							
28							
29							
30							
31							
32							
33							
34							

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	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:

01/01/09

Ending:

12/31/09

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	\$ 621,710	\$	\$ 62,201	\$ 62,201	10	\$ 287,219	71
72	Current Year Purchases	110,475		7,127	7,127	10	7,127	72
73	Fully Depreciated Assets	516,117				10	516,117	73
74								74
75	TOTALS	\$ 1,248,302	\$	\$ 69,328	\$ 69,328		\$ 810,463	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		3,301	3,301	5	66,022	77
78		FORD F150 TRUCK	2008	25,900		5,180	5,180	5	6,043	78
79										79
80	TOTALS			\$ 116,620	\$	\$ 8,481	\$ 8,481		\$ 96,763	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)	\$ 12,039,551	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 299,038	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 460,985	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 161,947	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,983,614	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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: \$ 12,306 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 547,711	\$		\$ 547,711	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			211,017			211,017	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			640,861			640,861	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 prescrpts				317,170		317,170	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					88,425	59,528		147,953	13
14	TOTAL			\$		\$ 1,488,014	\$ 376,698		\$ 1,864,712	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

0040899

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 5,131	\$ 126,507	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,349,146	2,349,146	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,695	22,695	6
7	Other Prepaid Expenses	10,697	10,697	7
8	Accounts Receivable (owners or related parties)	869,872	869,872	8
9	Other(specify): <u>See Attached Schedule</u>	233,579	233,579	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,491,620	\$ 3,612,996	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		94,987	13
14	Buildings, at Historical Cost		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)	(1,688,311)	(2,129,286)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	7,941	7,941	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 496,217	\$ 3,341,481	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,987,837	\$ 6,954,477	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,300,215	\$ 1,300,216	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,612	4,612	28
29	Short-Term Notes Payable	2,362,937	2,362,937	29
30	Accrued Salaries Payable	373,772	373,772	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,203	41,203	31
32	Accrued Real Estate Taxes(Sch.IX-B)	125,275	125,275	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	203,408	203,408	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,411,422	\$ 4,411,423	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,741,694	5,388,374	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,741,694	\$ 5,388,374	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,153,116	\$ 9,799,797	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,165,279)	\$ (2,845,320)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,987,837	\$ 6,954,477	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,360,746)	1
2	Restatements (describe):		2
3	Reduction in Draws	259,000	3
4	Rounding	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,101,743)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,063,536)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,063,536)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,165,279)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/09Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1		
Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 9,586,523	1	
2	Discounts and Allowances for all Levels	916,366	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,502,889	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	2,318,020	6	
7	Oxygen	92,611	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,410,631	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	12,913	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	315,135	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	25,712	19	
20	Radiology and X-Ray	5,382	20	
21	Other Medical Services	37,413	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 396,555	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	10,010	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,010	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>See Supplemental Schedule</u>	2,523	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,523	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,322,608	30	

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services	2,324,167	31	
32	Health Care	4,583,386	32	
33	General Administration	3,672,856	33	
B. Capital Expense				
34	Ownership	1,696,807	34	
C. Ancillary Expense				
35	Special Cost Centers	2,004,903	35	
36	Provider Participation Fee	104,025	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,386,144	40	
41	Income before Income Taxes (line 30 minus line 40)**	(1,063,536)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,063,536)	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:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,546	1,629	\$ 73,729	\$ 45.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,111	29,583	926,001	31.30	3
4	Licensed Practical Nurses	38,808	41,909	1,194,542	28.50	4
5	CNAs & Orderlies	117,889	125,629	1,540,646	12.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,044	8,741	144,491	16.53	8
9	Activity Director	2,109	2,166	39,676	18.32	9
10	Activity Assistants	15,665	16,328	153,190	9.38	10
11	Social Service Workers	8,331	8,845	190,406	21.53	11
12	Dietician					12
13	Food Service Supervisor	2,029	2,166	44,332	20.47	13
14	Head Cook	7,905	8,785	122,848	13.98	14
15	Cook Helpers/Assistants	25,771	27,211	258,077	9.48	15
16	Dishwashers					16
17	Maintenance Workers	4,099	4,428	63,235	14.28	17
18	Housekeepers	27,616	29,431	286,788	9.74	18
19	Laundry	8,181	8,846	74,819	8.46	19
20	Administrator	1,989	2,086	104,813	50.25	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,040	97,500	93.75	22
23	Office Manager					23
24	Clerical	18,191	19,410	354,387	18.26	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	1,999	2,208	46,969	21.27	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,737	4,986	123,997	24.87	33
34	TOTAL (lines 1 - 33)	323,060	345,427	\$ 5,840,446 *	\$ 16.91	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	217	\$ 10,067	01-03	35
36	Medical Director	monthly	41,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1	47	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	284	10a-03	43
44	Activity Consultant	86	4,999	11-03	44
45	Social Service Consultant	56	3,422	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	366	\$ 60,219		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	336	\$ 11,696	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	336	\$ 11,696		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Theodore O'Brien (1/1-3/2)	Administrator	0	\$ 23,292	Workers' Compensation Insurance	\$ 156,011	IDPH License Fee	\$	
Michael Pettinati (3/2-5/29)	Administrator	0	26,969	Unemployment Compensation Insurance	37,523	Advertising: Employee Recruitment	26,008	
David Zaruba (5/23-12/31)	Administrator	0	54,552	FICA Taxes	388,058	Health Care Worker Background Check	1,455	
Aaron Mann	Dir of Operations	0	97,500	Employee Health Insurance	254,343	(Indicate # of checks performed <u>146</u>)		
				Employee Meals	23,652	Patient Background Checks	202	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotion	48,139	
				Dental Insurance	5,965	Dues & Subscriptions	3,203	
				Other Employee Benefits	26,106	License, Inspection & Fees	13,711	
				401K Matching Expense	15,611			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 202,313			Non-allowable advertising	(48,139)	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Frost Ruttenberg & Rothblatt	Accounting	\$ 18,340			\$	Out-of-State Travel	\$	
Camille J. Koehl	Accounting	21,663						
Personnel Planners	Unemployment Consulting	1,841						
Various - See Attached	Legal	103,879				In-State Travel		
James O. Hamilton & Co.	Appraisal	3,500						
FEI Architect	Architect (Capitalized)	7,435						
Crowe Horwath	Accounting	14						
Pension Inc.	Pension Services	3,373				Seminar Expense	7,736	
Health Data Systems, Inc.	Computer Service	9,444						
Kaseya	Computer Service	5,625						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		Entertainment Expense	()	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 175,114		\$	(agree to Sch. V, line 24, col. 8)		
						TOTAL	\$ 7,736	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/09Ending: 12/31/09**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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,573 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. \$ 104,025
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 23,652 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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
- (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.