

Facility Name & ID Number Arlington Rehab & Living Center

0040899 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	42,794	4,063	14,722	61,579	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,794	4,063	14,722	61,579	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.79%

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 13,775

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	409,187	64,024	15,652	488,863		488,863	4,673	493,536		1
2	Food Purchase		321,619		321,619	(23,506)	298,113	(212)	297,901		2
3	Housekeeping	270,891	51,177		322,068		322,068		322,068		3
4	Laundry	74,815	33,440		108,255		108,255		108,255		4
5	Heat and Other Utilities			217,347	217,347		217,347	(13,322)	204,025		5
6	Maintenance	65,435	58,047	457,725	581,207		581,207	(332,741)	248,466		6
7	Other (specify):*							928	928		7
8	TOTAL General Services	820,328	528,307	690,724	2,039,359	(23,506)	2,015,853	(340,674)	1,675,179		8
	B. Health Care and Programs										
9	Medical Director			35,500	35,500		35,500		35,500		9
10	Nursing and Medical Records	3,696,712	190,270	5,604	3,892,586		3,892,586	61,934	3,954,520		10
10a	Therapy	167,821	942		168,763		168,763		168,763		10a
11	Activities	245,978	6,774	2,393	255,145		255,145		255,145		11
12	Social Services	230,404		2,648	233,052		233,052		233,052		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							11,994	11,994		15
16	TOTAL Health Care and Programs	4,340,915	197,986	46,145	4,585,046		4,585,046	73,928	4,658,974		16
	C. General Administration										
17	Administrative	125,010		639,474	764,484		764,484	(393,761)	370,723		17
18	Directors Fees										18
19	Professional Services			183,501	183,501		183,501	23,839	207,340		19
20	Dues, Fees, Subscriptions & Promotions			91,627	91,627		91,627	(38,090)	53,537		20
21	Clerical & General Office Expenses	260,863	40,597	154,934	456,394		456,394	(17,951)	438,443		21
22	Employee Benefits & Payroll Taxes			896,146	896,146	23,506	919,652		919,652		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,387	4,387		4,387	928	5,315		24
25	Other Admin. Staff Transportation			8,241	8,241		8,241	17,914	26,155		25
26	Insurance-Prop.Liab.Malpractice			1,066,852	1,066,852		1,066,852	605	1,067,457		26
27	Other (specify):*							47,671	47,671		27
28	TOTAL General Administration	385,873	40,597	3,045,162	3,471,632	23,506	3,495,138	(358,844)	3,136,294		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,547,116	766,890	3,782,031	10,096,037		10,096,037	(625,590)	9,470,447		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:

01/01/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			182,934	182,934		182,934	258,471	441,405			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			238,475	238,475		238,475	(238,475)	(0)			32
33	Real Estate Taxes			127,161	127,161		127,161		127,161			33
34	Rent-Facility & Grounds			1,136,582	1,136,582		1,136,582	(1,132,595)	3,987			34
35	Rent-Equipment & Vehicles			11,664	11,664		11,664	3,330	14,994			35
36	Other (specify):*											36
37	TOTAL Ownership			1,696,816	1,696,816		1,696,816	(1,109,269)	587,547			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		640,317	1,592,123	2,232,440		2,232,440	(164,854)	2,067,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	23,327		37,899	61,226		61,226	(27,114)	34,112			41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*	46,974			46,974		46,974	(46,974)				43
44	TOTAL Special Cost Centers	70,301	640,317	1,734,047	2,444,665		2,444,665	(238,942)	2,205,723			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,617,417	1,407,207	7,212,894	14,237,518		14,237,518	(1,973,801)	12,263,717			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	(13,322)	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	142,425	30		9
10	Interest and Other Investment Income	(12,442)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(212)	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	(957)	21		18
19	Entertainment	(6,913)	21		19
20	Contributions	(400)	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	(49,019)	21		24
25	Fund Raising, Advertising and Promotional	(51,492)	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	(899,823)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (892,154)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,081,647)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,081,647)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,973,801)		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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	52

Arlington Rehab & Living Center

ID# 0040899

Report Period Beginning: 01/01/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Patient Needs	\$ (6,177)	10	1
2	Bistro Income	(27,114)	41	2
3	Public Relations	(999)	20	3
4	Bank Charges	(10,940)	21	4
5	Credit Card Processing Fees	(1,942)	21	5
6	Collection Fees	(714)	21	6
7	Theft Loss Recovery	(184)	21	7
8	Jury Duty Income	(28)	10	8
9	Medical Records Income	(391)	10	9
10	Rental Income	(8,000)	21	10
11	Out of State Seminars	(348)	24	11
12	Marketing Travel	(1,797)	25	12
13	Bank Charges - Building Co	(721)	21	13
14	Legal & Accounting Fees - Building Co	(2,399)	19	14
15	Management Fees - Building Co	(59,972)	19	15
16	State Income Tax - Building Co	(11,751)	21	16
17	Trust Fees - Building Co	(630)	21	17
18	Non-Allowable Interest Expense	(378,898)	32	18
19	Capitalized R&M	(90,641)	06	19
20	Non-Allowable Salary	(6,447)	43	20
21	Non-Allowable and out of Period Legal	(6,968)	19	21
22	Prior Period Expense	(242,234)	06	22
23	Marketing Salaries	(40,527)	43	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	(899,823)		49

Arlington Rehab & Living Center

ID# 0040899

Report Period Beginning: 01/01/10

Ending: 12/31/10

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:

01/01/10

Ending:

12/31/10

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				4,673								4,673	1
2	Food Purchase	(212)											(212)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,322)											(13,322)	5
6	Maintenance	(332,875)			134								(332,741)	6
7	Other (specify):*				928								928	7
8	TOTAL General Services	(346,409)			5,735								(340,674)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,596)			68,530								61,934	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				11,994								11,994	15
16	TOTAL Health Care and Programs	(6,596)			80,524								73,928	16
	C. General Administration													
17	Administrative				(393,761)								(393,761)	17
18	Directors Fees													18
19	Professional Services	(69,339)	62,371		30,807								23,839	19
20	Fees, Subscriptions & Promotions	(52,891)			14,801								(38,090)	20
21	Clerical & General Office Expenses	(91,771)	12,143		61,678								(17,951)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(348)			1,276								928	24
25	Other Admin. Staff Transportation	(1,797)			19,712								17,914	25
26	Insurance-Prop.Liab.Malpractice				605								605	26
27	Other (specify):*				47,671								47,671	27
28	TOTAL General Administration	(216,146)	74,514		(217,211)								(358,844)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(569,151)	74,514		(130,953)								(625,590)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	142,425	116,046										258,471	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(391,340)	147,421		5,444								(238,475)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,136,582)		3,987								(1,132,595)	34
35	Rent-Equipment & Vehicles				3,330								3,330	35
36	Other (specify):*													36
37	TOTAL Ownership	(248,915)	(873,115)		12,760								(1,109,269)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(164,854)									(164,854)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(27,114)											(27,114)	41
42	Provider Participation Fee													42
43	Other (specify):*	(46,974)											(46,974)	43
44	TOTAL Special Cost Centers	(74,088)		(164,854)									(238,942)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(892,154)	(798,601)	(164,854)	(118,192)								(1,973,801)	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		Aurora 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:	
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	\$ 1,136,582	Kedzie Home LLC	100.00%	\$	\$ (1,136,582)	1
2	V	30 Depreciation		Kedzie Home LLC	100.00%	116,046	116,046	2
3	V	32 Interest Expense		Kedzie Home LLC	100.00%	147,421	147,421	3
4	V	21 Bank Charges		Kedzie Home LLC	100.00%	721	721	4
5	V	19 Legal & Accounting		Kedzie Home LLC	100.00%	2,399	2,399	5
6	V	19 Management Fees		Kedzie Home LLC	100.00%	59,972	59,972	6
7	V	21 Taxes - Franchise & State	959	Kedzie Home LLC	100.00%		(959)	7
8	V	21 State Income Tax		Kedzie Home LLC	100.00%	11,751	11,751	8
9	V	21 Trust Fees		Kedzie Home LLC	100.00%	630	630	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,137,541			\$ 338,940	\$ * (798,601)	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	\$ 1,564,559	Simply Rehab		\$ 1,399,705	\$ (164,854)
16	V						
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		\$ 1,564,559			\$ 1,399,705	\$ * (164,854)

* 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	<u>1</u> <u>DIETARY CONSULTANT SALARIES</u>	\$	<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	\$ 4,673	\$ 4,673
16	V	<u>6</u> <u>BUILDING SUPPLIES</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	134	134
17	V	<u>7</u> <u>EMP. BEN. - GENERAL</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	928	928
18	V	<u>10</u> <u>NURSING SALARIES</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	68,530	68,530
19	V	<u>15</u> <u>EMP. BEN. - NURSING</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	11,994	11,994
20	V	<u>17</u> <u>ADMINISTRATIVE SALARIES - NON OWNER</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	130,609	130,609
21	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	30,807	30,807
22	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	14,801	14,801
23	V	<u>21</u> <u>OFFICE SALARIES</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	324	324
24	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	61,354	61,354
25	V	<u>24</u> <u>SEMINARS</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	1,276	1,276
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	17,925	17,925
27	V	<u>26</u> <u>INSURANCE</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	605	605
28	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	47,671	47,671
29	V	<u>32</u> <u>INTEREST</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	5,444	5,444
30	V	<u>34</u> <u>RENT</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	3,987	3,987
31	V	<u>35</u> <u>AUTO RENTAL</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	2,585	2,585
32	V	<u>35</u> <u>EQUIPMENT RENTAL</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	744	744
33	V	<u>17</u> <u>REGIONAL MANAGER - ILLINOIS ONLY</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	115,104	115,104
34	V	<u>25</u> <u>ILLINOIS ONLY - TRAVEL</u>		<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%	1,787	1,787
35	V						
36	V						
37	V	<u>17</u> <u>MANAGEMENT FEES</u>	639,474	<u>APEX HEALTHCARE SOLUTIONS LLC</u>	100.00%		(639,474)
38	V						
39	Total		\$ 639,474			\$ 521,282	\$ * (118,192)

* 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: 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: 01/01/10 Ending: 12/31/10

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 of Operation	Administrative	0	See Attached	23	57.50%	Alloc. Salary	\$ 115,104	17-03	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	\$ 115,104		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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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		\$	\$		1,399,705	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				\$	\$		1,399,705	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 APEX HEALTHCARE SOLUTIONS LLC
 Street Address 1668 CHECKER ROAD
 City / State / Zip Code LONG GROVE, IL 60047
 Phone Number (877) 860-2739
 Fax Number (847) 419-1372

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	DIETARY CONSULTANT SAL	MGMT FEES/PAT DAYS	420,185	14	\$ 31,886	\$ 31,886	61,579	\$ 4,673	1
2	6	BUILDING SUPPLIES	MGMT FEES/PAT DAYS	420,185	14	917		61,579	134	2
3	7	EMP. BEN. - GENERAL	MGMT FEES/PAT DAYS	420,185	14	6,329		61,579	928	3
4	10	NURSING SALARIES	MGMT FEES/PAT DAYS	420,185	14	467,616	467,616	61,579	68,530	4
5	15	EMP. BEN, - NURSING	MGMT FEES/PAT DAYS	420,185	14	81,840		61,579	11,994	5
6	17	ADMINISTRATIVE SALARIES	MGMT FEES/PAT DAYS	420,185	14	891,211	891,211	61,579	130,609	6
7	19	PROFESSIONAL FEES	MGMT FEES/PAT DAYS	420,185	14	210,214	210,214	61,579	30,807	7
8	20	FEES, SUBSCRIPTIONS	MGMT FEES/PAT DAYS	420,185	14	100,995		61,579	14,801	8
9	21	OFFICE SALARIES	MGMT FEES/PAT DAYS	420,185	14	2,210		61,579	324	9
10	21	CLERICAL & GENERAL	MGMT FEES/PAT DAYS	420,185	14	418,647	418,647	61,579	61,354	10
11	24	SEMINARS	MGMT FEES/PAT DAYS	420,185	14	8,707		61,579	1,276	11
12	25	AUTO AND TRAVEL	MGMT FEES/PAT DAYS	420,185	14	122,312		61,579	17,925	12
13	26	INSURANCE	MGMT FEES/PAT DAYS	420,185	14	4,127		61,579	605	13
14	27	EMP. BEN.-GEN. ADMIN.	MGMT FEES/PAT DAYS	420,185	14	325,285		61,579	47,671	14
15	32	INTEREST	MGMT FEES/PAT DAYS	420,185	14	37,145		61,579	5,444	15
16	34	RENT	MGMT FEES/PAT DAYS	420,185	14	27,203		61,579	3,987	16
17	35	AUTO RENTAL	MGMT FEES/PAT DAYS	420,185	14	17,642		61,579	2,585	17
18	35	EQUIPMENT RENTAL	MGMT FEES/PAT DAYS	420,185	14	5,080		61,579	744	18
19	17	REGIONAL MANAGER - ILLI	DIRECT/PAT DAYS	102,486	2	191,568		61,579	115,104	19
20	25	ILLINOIS ONLY - TRAVEL	DIRECT/PAT DAYS	102,486	2	2,974		61,579	1,787	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,953,907	\$ 2,019,574		\$ 521,282	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending:

12/31/10

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8	Venture Fund	X		Working Capital			\$	\$ 1,571,110		\$ 126,942	8									
9	Venture Fund (Bldg Co)	X		Working Capital				2,522,381		147,421	9									
10	Adjusted on page 5									(378,898)	10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

(See instructions.)

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:

01/01/10

Ending:

12/31/10

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	23,400	9
10	Various		1997	34,251		20	1,713	1,713	20,952	10
11	Various		1998	115,118		20	5,756	5,756	71,069	11
12	Various		1999	8,794		20	440	440	4,630	12
13	Various		2000	5,943		20	107	107	5,537	13
14	Various		2001	11,296		20	565	565	5,393	14
15	Various		2002	41,668		20	4,167	4,167	34,863	15
16	Various		2003	12,639		20	1,264	1,264	9,227	16
17	Various		2004	102,913		20	10,291	10,291	67,041	17
18	Various		2005	443,001		20	23,101	23,101	126,197	18
19	Various		2006	122,772		20	11,584	11,584	48,578	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

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		6,022,246	116,046		177,366	61,320	1,675,201	67
68								68
69			182,934			(182,934)		69
70		\$ 6,952,216	\$ 298,980		\$ 237,867	\$ (61,113)	\$ 2,092,089	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:

01/01/10

Ending:

12/31/10**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		\$ 6,952,216	\$ 298,980		\$ 237,867	\$ (61,113)	\$ 2,092,089	1
2	<u>Sprinkler Repairs/Pump Room</u>	2007	5,301		20	530	530	2,032	2
3	<u>Rebuilt Laundry Boiler</u>	2007	3,390		20	283	283	1,083	3
4	<u>New Domestic Water Treatment System</u>	2007	13,178		20	1,318	1,318	4,722	4
5	<u>Restore Unit Electronic Door</u>	2007	2,363		20	236	236	807	5
6	<u>Lobby Remodeling & Flooring</u>	2007	3,413		20	341	341	1,308	6
7	<u>Office & Copy Room Remodeling</u>	2007	3,120		20	312	312	1,066	7
8	<u>Flooring</u>	2007	41,469		20	2,073	2,073	6,393	8
9	<u>Carpet</u>	2007	3,254		20	163	163	502	9
10	<u>Bedroom Flooring</u>	2007	11,800		20	590	590	1,819	10
11	<u>Storage & Dining Buildout</u>	2007	3,512		20	176	176	702	11
12	<u>Dining, Therapy, Office Buildout</u>	2007	10,433		20	522	522	2,043	12
13	<u>Sprinkler System - Replace Piping</u>	2007	14,116		20	706	706	2,647	13
14	<u>Fin Frame & Screen</u>	2007	3,430		20	172	172	600	14
15	<u>Deck, Structural Installation, Anchor Bolts, Set Plates</u>	2007	144,688		20	7,234	7,234	24,115	15
16	<u>Plastering & Repairs</u>	2007	2,650		20	133	133	442	16
17	<u>Fencing & Night Light Fixtures</u>	2007	10,337		20	517	517	1,723	17
18	<u>Paint Steel Balconies</u>	2007	5,700		20	285	285	926	18
19	<u>Bathfloor Tiles</u>	2007	14,699		20	735	735	2,389	19
20	<u>Landscaping Level Ground, Top Soil</u>	2007	5,000		20	250	250	792	20
21	<u>Hvac Unit</u>	2007	7,926		20	396	396	1,255	21
22	<u>Roof Replacement</u>	2007	22,950		20	1,148	1,148	3,538	22
23	<u>Curtains, End Caps, Splices</u>	2007	4,525		20	226	226	698	23
24	<u>Framing & Drywall, Insulations, Access Panels</u>	2007	134,700		20	6,735	6,735	20,766	24
25	<u>Sliding Door Tracks, Shower Receptors</u>	2007	21,153		20	1,058	1,058	3,261	25
26	<u>Steel Work</u>	2007	4,580		20	229	229	821	26
27	<u>Shower Area Radiant Piping / Concrete Prep</u>	2007	5,510		20	276	276	964	27
28	<u>Barricades, Windows, Shower Bases, Patch Holes</u>	2007	7,430		20	372	372	1,269	28
29	<u>Brick Walls, Ceramic Tiling, Insulation, Caulking</u>	2007	14,211		20	711	711	2,250	29
30	<u>New Unit Drapery</u>	2008	8,156		20	408	408	1,223	30
31	<u>New Phone System</u>	2008	21,103		20	1,055	1,055	2,726	31
32	<u>Wall Coverings - New Unit</u>	2008	6,763		20	338	338	986	32
33	<u>Resurface Parking Lot</u>	2008	43,650		20	2,183	2,183	5,093	33
34	TOTAL (lines 1 thru 33)		\$ 7,556,726	\$ 298,980		\$ 269,574	\$ (29,406)	\$ 2,193,050	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:

01/01/10

Ending:

12/31/10**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		\$ 7,556,726	\$ 298,980		\$ 269,574	\$ (29,406)	\$ 2,193,050	1
2	Plumbing	2008	9,274		20	464	464	1,159	2
3	Flooring	2008	5,343		20	267	267	623	3
4	Flooring	2008	27,646		20	1,382	1,382	3,917	4
5	Flooring	2008	27,646		20	1,382	1,382	3,917	5
6	Flooring	2008	27,646		20	1,382	1,382	3,801	6
7	Flooring	2008	17,898		20	895	895	2,461	7
8	Flooring	2008	16,129		20	806	806	2,151	8
9	Flooring	2008	5,376		20	269	269	672	9
10	Carpet	2008	2,797		20	140	140	385	10
11	Carpet	2008	4,813		20	241	241	642	11
12	Carpet	2008	3,534		20	177	177	501	12
13	Carpet	2008	2,799		20	140	140	397	13
14	Service Outside Lights	2008	5,997		20	300	300	700	14
15	Flooring & Installation	2008	50,000		20	2,500	2,500	7,083	15
16	Repair Fixture Sockets	2008	2,611		20	131	131	294	16
17	Remodeling - Transfer Fan	2008	4,080		20	204	204	442	17
18	Repair Basement, Dish Room, Kitchen , Door, Security Devices	2008	4,208		20	210	210	508	18
19	Electrical Work	2008	7,412		20	371	371	927	19
20	Flooring, Laundry & Dining Room Repairs	2008	10,103		20	505	505	1,094	20
21	Painting, Stain, Door & Frames	2008	13,174		20	659	659	1,811	21
22	Flooring	2008	15,674		20	784	784	2,090	22
23	Floor Repair & Clinical Service Sink	2008	18,515		20	926	926	2,546	23
24	Flooring & Carpet	2008	19,036		20	952	952	2,538	24
25	Demolition, Drywall, Paint	2008	28,704		20	1,435	1,435	3,827	25
26	Repair E.I.F.S.	2008	9,600		20	480	480	1,240	26
27	Underground Well System Repair	2008	2,800		20	140	140	362	27
28	Bathroom Flooring	2008	6,476		20	324	324	782	28
29	Floor Installation	2008	7,484		20	374	374	936	29
30	Ceiling Tile, Shelving, Painting	2008	10,915		20	546	546	1,546	30
31	Flooring & Carpet	2008	3,516		20	176	176	498	31
32	Bedroom Floor & Wall Base	2008	17,071		20	854	854	2,418	32
33	Therapy Room Flooring	2008	7,904		20	395	395	1,120	33
34	TOTAL (lines 1 thru 33)		\$ 7,952,906	\$ 298,980		\$ 289,383	\$ (9,597)	\$ 2,246,437	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:

01/01/10

Ending:

12/31/10**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		\$ 7,952,906	\$ 298,980		\$ 289,383	\$ (9,597)	\$ 2,246,437	1
2	Bedroom Flooring	2008	20,359		20	1,018	1,018	2,884	2
3	Bedroom Flooring	2008	21,644		20	1,082	1,082	2,976	3
4	Lobby & Dining Room Flooring	2008	9,255		20	463	463	1,273	4
5	Flooring	2008	3,303		20	165	165	372	5
6	Flooring	2008	11,895		20	595	595	1,536	6
7	Plumbing - Dishwashing Room	2008	3,314		20	166	166	400	7
8	Bathroom Flooring	2008	3,670		20	184	184	444	8
9	Flooring	2008	6,166		20	308	308	848	9
10	Flooring	2008	17,855		20	893	893	2,455	10
11	Toilets	2008	25,768		20	1,288	1,288	3,114	11
12	Carpet	2008	2,817		20	141	141	376	12
13	Doors & Frames, Hager Strip, Power Supply, Keypads, Hinges	2008	30,425		20	1,521	1,521	4,564	13
14	Insulate Fore Access Panel, Door	2008	2,823		20	141	141	423	14
15	Data & Cable Wiring, Termination, Testing	2008	4,560		20	228	228	684	15
16	Ceiling Grid, Painting Walls, Ceilings, Doors	2008	35,360		20	1,768	1,768	5,304	16
17	Excavation & Concrete, Grading Walls, Strip Dirt, Trench For Fo	2008	184,788		20	9,239	9,239	27,718	17
18	Tile Base And Bath Floor Tiles	2008	11,037		20	552	552	1,656	18
19	Flooring, Ceramic Tiles, Carpeting	2008	10,884		20	544	544	1,587	19
20	Carpeting	2008	5,477		20	274	274	799	20
21	Sprinklers-Piping, Valves, Trim, Repairs For Tie-Ins, Certification	2008	50,933		20	2,547	2,547	7,428	21
22	Piping System Installation	2008	168,690		20	8,435	8,435	24,601	22
23	Doors, Showers, Bathroom, Curtains	2008	42,165		20	2,108	2,108	6,149	23
24	Hallway & Dining Room Wallpaper	2008	5,275		20	264	264	769	24
25	Radiant Heating	2008	110,295		20	5,515	5,515	16,085	25
26	Electrical Work, Lighting, Alarm	2008	288,122		20	14,406	14,406	43,218	26
27	Remodeling - Carpet Fire Treatment	2008	5,177		20	259	259	539	27
28	Base Boards	2009	13,807		20	690	690	1,093	28
29	Railings	2009	17,901		20	895	895	1,417	29
30	Base Boards	2009	7,789		20	389	389	617	30
31	Wallcovering	2009	23,908		20	1,195	1,195	2,291	31
32	Flooring	2009	6,720		20	336	336	644	32
33	Countertops	2009	13,613		20	681	681	1,305	33
34	TOTAL (lines 1 thru 33)		\$ 9,118,700	\$ 298,980		\$ 347,673	\$ 48,693	\$ 2,412,004	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:

01/01/10

Ending:

12/31/10**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		\$ 9,118,700	\$ 298,980		\$ 347,673	\$ 48,693	\$ 2,412,004	1
2	Nurses Station Remodel	2009	2,999		20	150	150	275	2
3	Brickwork	2009	2,528		20	126	126	221	3
4	Relocated Bathroom	2009	5,725		20	286	286	525	4
5	Lobby Remodel - Architect Services	2009	6,449		20	322	322	618	5
6	Remodel Work - Walls & Flooring	2009	21,552		20	1,078	1,078	1,976	6
7	Remodel Work - Painting & Plaster Work	2009	6,620		20	331	331	634	7
8	Therapy Remodel - Demolish Office, Rebuilt Framing	2009	5,040		20	252	252	483	8
9	Electrical Work	2009	3,433		20	172	172	329	9
10	Coordination Of Remodeling, Water System Corrections	2009	10,174		20	509	509	975	10
11	Flooring & Walls	2009	7,700		20	385	385	770	11
12	Remodel Work - Relocate Piping	2009	6,560		20	328	328	574	12
13	Remodel Bistro- Insulation	2009	8,925		20	446	446	707	13
14	Remodeling - Floors, Wall Cover, Handrails	2009	11,650		20	583	583	1,019	14
15	Remodeling - Walls & Floors	2009	12,526		20	626	626	1,096	15
16	Remodel Work In Bathroom, Kitchen And Salon	2009	22,773		20	1,139	1,139	1,898	16
17	Remodeling - Floors & Handrails	2009	23,874		20	1,194	1,194	1,890	17
18	Remodeling - Walls	2009	10,033		20	502	502	669	18
19	Bathroom Remodel- Wall/Floor Tiles, Paint, Light Fixtures	2009	18,385		20	919	919	1,072	19
20	Bathroom Remodel- Wall/Floor Tiles Paint	2009	30,950		20	1,548	1,548	1,805	20
21	Remodeling - Floors	2009	3,650		20	183	183	213	21
22	Therapy Room Remodel - Floors, Walls, Ceiling	2009	6,288		20	314	314	550	22
23	Walls, Flooring, Painting	2009	11,580		20	579	579	965	23
24	Bistro - Granite Countertops & Backsplash	2009	3,595		20	180	180	300	24
25	Electrical Work For Remodeling	2009	23,923		20	1,196	1,196	2,193	25
26	Electrical Work For Remodeling	2009	12,478		20	624	624	936	26
27	Remodeling - Floors, Painting, Plumbing	2009	34,209		20	1,710	1,710	2,993	27
28	Remodeling - Floors, Painting, Plumbing	2009	34,723		20	1,736	1,736	2,749	28
29	Sprinkler Work	2009	8,460		20	423	423	705	29
30	Architect Fees - Remodeling	2009	7,435		20	372	372	496	30
31	Construction Of 3 Walls	2010	6,292		20	315	315	315	31
32	Rough-In Only For Sink And Open Site Drain	2010	6,815		20	341	341	341	32
33	Heat Exchanger For Boiler	2010	3,608		20	180	180	180	33
34	TOTAL (lines 1 thru 33)		\$ 9,499,651	\$ 298,980		\$ 366,721	\$ 67,741	\$ 2,442,476	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:

01/01/10

Ending:

12/31/10

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		9,499,651	298,980		366,721	67,741	2,442,476	1
2	Boiler	2010	3,269		20	163	163	163	2
3	Deep Well Pump Repairs	2010	8,945		20	447	447	447	3
4	Fire Dampers	2010	4,943		20	247	247	247	4
5	Pull Pipe, O-Rings, 6' Motor	2010	29,117		20	1,456	1,456	1,456	5
6	Coordination Of Site, Permit Issues, Lsc Survey	2010	4,993		20	250	250	250	6
7	Lsc Survey Repairs, Site Issues, Fans	2010	5,251		20	263	263	263	7
8	Water Plant Wall Repair, Cooler Installation	2010	7,719		20	386	386	386	8
9	Door Repairs, Hinge Replacement, It Cooler Ducting, Installation.	2010	9,689		20	484	484	484	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		9,573,577	298,980		370,417	71,437	2,446,172	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	Building Company Information		\$	\$		\$	\$		1
2	Buidlings:								2
3		1996	20,105		35	1,005	1,005	15,077	3
4		1995	5,614,638		35	160,418	160,418	1,604,181	4
5	East Addition	2008	160,181		35	4,577	4,577	44,577	5
6	Building Company Book Depreciation			116,046			(116,046)		6
7									7
8	Leasehold Improvements:								8
9	Building Supplies	2008	4,371		20	219	219	219	9
10	Remodel Bathing Area in Room 344	2008	13,770		20	689	689	689	10
11	Architectural Services	2008	9,874		20	494	494	494	11
12	Remodel Shower Rooms 517 and 519	2008	4,407		20	220	220	220	12
13	Construction-Home Depot	2008	4,690		20	235	235	235	13
14	Electirc Work	2008	37,907		20	1,895	1,895	1,895	14
15	Furnish & Install one stair Assembly with Header	2008	4,400		20	220	220	220	15
16	Framing, Drywall Hanging and Painting New Partitions	2008	103,064		20	5,153	5,153	5,153	16
17	Concrect Floor Openeing	2008	4,600		20	230	230	230	17
18	East Addition And Wing 300 Remodeling	2008	25,853		20	1,293	1,293	1,293	18
19	Exhaust System	2008	14,386		20	719	719	719	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 (12G lines 1 thru 33)		\$ 6,022,246	\$ 116,046		\$ 177,366	\$ 61,320	\$ 1,675,201	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									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									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:

01/01/10

Ending:

12/31/10

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	\$ 661,061	\$	\$ 65,808	\$ 65,808	10	\$ 289,024	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	587,238				10	587,238	73
74								74
75	TOTALS	\$ 1,248,298	\$	\$ 65,808	\$ 65,808		\$ 876,262	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				5	66,022	77
78		FORD F150 TRUCK	2008	25,900		5,180	5,180	5	11,223	78
79										79
80	TOTALS			\$ 116,620	\$	\$ 5,180	\$ 5,180		\$ 101,943	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)	\$ 11,110,688	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 298,980	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 441,405	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 142,425	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,424,377	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	<u>Allocated from APEX HC Solutions</u>				<u>3,987</u>			5
6								6
7	TOTAL				\$ <u>3,987</u>			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: \$ 12,407 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from APEX HC Solutions</u>		\$	\$ <u>2,585</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,585</u>	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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	\$		\$	589,301	\$			\$	589,301	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				204,067					204,067	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				774,689					774,689	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						508,915			508,915	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>						24,066		131,402			155,468	13	
14	TOTAL			\$		\$	1,592,123	\$	640,317	\$		2,232,440	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: 01/01/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 779,509	\$ 908,706	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	849,529	849,529	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,368	7,368	6
7	Other Prepaid Expenses	17,181	17,181	7
8	Accounts Receivable (owners or related parties)	506,654	506,654	8
9	Other(specify): <u>See Attached Schedule</u>	304,633	304,633	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,465,374	\$ 2,594,571	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	988,098	988,098	15
16	Equipment, at Historical Cost	579,926	579,926	16
17	Accumulated Depreciation (book methods)	(1,181,180)	(1,738,200)	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)	\$ 394,785	\$ 3,124,004	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,860,159	\$ 5,718,575	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,279,025	\$ 1,296,751	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,141	2,141	28
29	Short-Term Notes Payable	1,571,110	1,571,110	29
30	Accrued Salaries Payable	89,525	89,525	30
31	Accrued Taxes Payable (excluding real estate taxes)	95,301	95,301	31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,296	129,296	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>	38,491	38,491	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,204,889	\$ 3,222,615	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,704,593	5,226,974	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)	\$ 2,704,593	\$ 5,226,974	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,909,482	\$ 8,449,589	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,049,323)	\$ (2,731,014)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,860,159	\$ 5,718,575	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,165,279)	1
2	Restatements (describe):		2
3	Reduction in Draws	97,248	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,068,031)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	18,708	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)	\$ 18,708	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)	\$ (3,049,323)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/10Ending: 12/31/10

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	\$ 9,741,378	1
2	Discounts and Allowances for all Levels	1,033,188	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,774,566	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,872,840	6
7	Oxygen	33,785	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,906,625	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	27,114	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	448,267	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,609	19
20	Radiology and X-Ray	6,779	20
21	Other Medical Services	23,977	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 542,746	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,545	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,545	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	18,744	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,744	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,256,226	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,039,359	31
32	Health Care	4,585,046	32
33	General Administration	3,471,632	33
B. Capital Expense			
34	Ownership	1,696,816	34
C. Ancillary Expense			
35	Special Cost Centers	2,340,640	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)*	\$ 14,237,518	40
41	Income before Income Taxes (line 30 minus line 40)**	18,708	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 18,708	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:

01/01/10

Ending:

12/31/10

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	2,305	2,429	\$ 112,684	\$ 46.39	1
2	Assistant Director of Nursing	1,607	1,787	64,262	35.96	2
3	Registered Nurses	21,251	23,189	743,968	32.08	3
4	Licensed Practical Nurses	41,262	42,427	1,073,228	25.30	4
5	CNAs & Orderlies	112,645	118,895	1,653,982	13.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,834	8,413	167,821	19.95	8
9	Activity Director	1,778	1,826	34,280	18.77	9
10	Activity Assistants	19,202	20,557	211,698	10.30	10
11	Social Service Workers	10,035	10,654	230,404	21.63	11
12	Dietician					12
13	Food Service Supervisor	1,693	1,808	37,931	20.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,152	31,317	371,256	11.85	15
16	Dishwashers					16
17	Maintenance Workers	4,091	4,203	65,435	15.57	17
18	Housekeepers	25,357	27,663	270,891	9.79	18
19	Laundry	7,784	8,272	74,815	9.04	19
20	Administrator	2,096	2,160	125,010	57.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,712	15,181	260,863	17.18	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	2,133	2,229	48,588	21.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,538	5,024	63,854	12.71	33
34	TOTAL (lines 1 - 33)	302,475	328,034	\$ 5,610,970 *	\$ 17.10	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	Monthly	\$ 15,652	01-03	35
36	Medical Director	Monthly	35,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,604	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,393	11-03	44
45	Social Service Consultant	48	2,648	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	92	\$ 61,797		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
David Zaruba	Administrator	0	\$ 125,010	Workers' Compensation Insurance	\$ 140,402	IDPH License Fee	\$	
				Unemployment Compensation Insurance	55,675	Advertising: Employee Recruitment	17,700	
				FICA Taxes	423,698	Health Care Worker Background Check	1,050	
				Employee Health Insurance	248,625	(Indicate # of checks performed <u>78</u>)		
				Employee Meals	23,506	Patient Background Checks	2,730	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotions	51,492	
				Dental Insurance	8,282	Dues & Subscriptions	2,100	
				Vision Insurance	744	License, Inspection & Fees	15,156	
				Other Employee Benefits	9,818	Allocated from APEX HC Solutions	14,801	
				Holiday Expense	1,365			
				401K Matching Expense	7,537	Less: Public Relations Expense	()	
						Non-allowable advertising	(51,492)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 919,652	\$ 53,537		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Apex Healthcare Solutions - Management Fees							Out-of-State Travel	
\$ 639,474							\$	
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 639,474				\$			4,040	
							Allocated from APEX HC Solutions	
							1,276	
C. Professional Services							Entertainment Expense	
Vendor/Payee							()	
Type							(agree to Sch. V, line 24, col. 8)	
Amount							\$ 5,316	
Frost Ruttenberg & Rothblatt								
Accounting								
\$ 24,544								
See Attached								
Legal								
106,785								
Personnel Planners								
Unemployment Consulting								
1,500								
ADI								
Computer Services								
1,116								
American Data								
Computer Services								
6,255								
Andover Network Liquidators								
Computer Services								
50								
Apex Healthcare Solutions								
Computer Services								
2,439								
CWD								
Computer Services								
6,526								
Emdeon Business Srv								
Computer Services								
956								
Health Data Systems								
Computer Services								
15,473								
MDI Achieve								
Computer Software								
6,199								
See Supplemental Schedule								
11,658								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 183,500				\$				

* 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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arlington Rehab & Living Center# 0040899Report Period Beginning: 01/01/10Ending: 12/31/10**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. \$ 51,665 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. \$ 23,506 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.