

Facility Name & ID Number Aurora Rehab & Living Center

0040097 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 10/18/10

	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	195	Skilled (SNF)	158	68,400	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	195	TOTALS	158	68,400	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	27,033	3,004	10,870	40,907	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,033	3,004	10,870	40,907	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.81%

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)
N/A

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 1973

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 158 and days of care provided 6,867

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCURAL 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 Aurora Rehab & Living Center # 0040097 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	346,107	47,739	13,118	406,964		406,964	3,104	410,068		1
2	Food Purchase		209,501		209,501		209,501	(153)	209,348		2
3	Housekeeping	202,504	32,339		234,843		234,843		234,843		3
4	Laundry	62,098	20,448		82,546		82,546		82,546		4
5	Heat and Other Utilities			177,562	177,562		177,562	(13,922)	163,640		5
6	Maintenance	106,125	44,626	1,057,102	1,207,853		1,207,853	(585,298)	622,555		6
7	Other (specify):*							616	616		7
8	TOTAL General Services	716,834	354,653	1,247,782	2,319,269		2,319,269	(595,653)	1,723,616		8
	B. Health Care and Programs										
9	Medical Director			37,000	37,000		37,000		37,000		9
10	Nursing and Medical Records	2,699,322	126,647	644	2,826,613		2,826,613	45,525	2,872,138		10
10a	Therapy	139,266	2,851	850	142,967		142,967	(37)	142,930		10a
11	Activities	128,419	3,716	6,024	138,159		138,159		138,159		11
12	Social Services	57,540		5,108	62,648		62,648		62,648		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,967	7,967		15
16	TOTAL Health Care and Programs	3,024,547	133,214	49,626	3,207,387		3,207,387	53,455	3,260,842		16
	C. General Administration										
17	Administrative	88,986		471,945	560,931		560,931	(308,717)	252,214		17
18	Directors Fees										18
19	Professional Services			169,249	169,249	(4,769)	164,480	(3,319)	161,161		19
20	Dues, Fees, Subscriptions & Promotions			43,933	43,933		43,933	(21,559)	22,374		20
21	Clerical & General Office Expenses	218,942	21,812	90,176	330,930		330,930	6,052	336,982		21
22	Employee Benefits & Payroll Taxes			805,773	805,773		805,773		805,773		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,972	1,972		1,972	848	2,820		24
25	Other Admin. Staff Transportation			11,924	11,924		11,924	13,094	25,018		25
26	Insurance-Prop.Liab.Malpractice			123,561	123,561		123,561	402	123,963		26
27	Other (specify):*							31,668	31,668		27
28	TOTAL General Administration	307,928	21,812	1,718,533	2,048,273	(4,769)	2,043,504	(281,531)	1,761,973		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,049,309	509,679	3,015,941	7,574,929	(4,769)	7,570,160	(823,728)	6,746,432		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 Aurora Rehab & Living Center

#0040097

Report Period Beginning:

01/01/10

Ending:

12/31/10

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			74,109	74,109		74,109	273,324	347,433			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			285,660	285,660		285,660	(268,531)	17,129			32
33	Real Estate Taxes			107,006	107,006	4,769	111,775		111,775			33
34	Rent-Facility & Grounds			798,463	798,463		798,463	(798,463)				34
35	Rent-Equipment & Vehicles			13,111	13,111		13,111	2,212	15,323			35
36	Other (specify):*											36
37	TOTAL Ownership			1,278,349	1,278,349	4,769	1,283,118	(791,458)	491,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		258,184	847,045	1,105,229		1,105,229	(18,140)	1,087,089			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	16,908		22,943	39,851		39,851	(23,107)	16,744			41
42	Provider Participation Fee			102,600	102,600		102,600		102,600			42
43	Other (specify):*	88,484			88,484		88,484	(88,484)	0			43
44	TOTAL Special Cost Centers	105,392	258,184	972,588	1,336,164		1,336,164	(129,731)	1,206,433			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,154,701	767,863	5,266,878	10,189,442		10,189,442	(1,744,918)	8,444,524			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Aurora Rehab & Living Center**

0040097

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	(13,922)	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	151,811	30		9
10	Interest and Other Investment Income	(45)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(153)	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	(21,000)	21		18
19	Entertainment	(94)	21		19
20	Contributions	(25)	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				24
25	Fund Raising, Advertising and Promotional	(31,366)	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	(1,128,927)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,043,721)		\$	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)	(701,196)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (701,196)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,744,918)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Aurora Rehab & Living Center

ID# 0040097

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bistro Income	\$ (23,107)	41	1
2	Bank Charges	(11,832)	21	2
3	Credit Card Processing Fees	(1,222)	21	3
4	Collections Fees	(732)	21	4
5	Marketing Wages	(88,484)	43	5
6	Medical Records Income	(40)	21	6
7	Prior Period Maintenance	(427,889)	06	7
8	Capitalized R&M - Post Capital Report	(157,498)	06	8
9	Non-Allowable Legal	(22,205)	19	9
10	Building Company - Bank Charges	(629)	21	10
11	Building Company - Accounting Fees	(6,645)	19	11
12	Building Company - Legal Fees	(8,848)	19	12
13	Building Company - Other Professional Fees	(36,424)	19	13
14	Building Company - Trust Fees	(500)	20	14
15	Building Company - Franchise Taxes	(175)	21	15
16	Building Company - Misceallaneous Office	(108)	21	16
17	Non-Allowable Interest Expense - Bldg. Co.	(77,320)	32	17
18	Non-Allowable Interest Expense - Facility	(260,309)	32	18
19	Dividend Income	(4,960)	32	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,128,927)		49

Aurora Rehab & Living Center

ID# 0040097

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 Aurora Rehab & Living Center# 0040097

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			3,104									3,104	1
2	Food Purchase	(153)											(153)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,922)											(13,922)	5
6	Maintenance	(585,387)		89									(585,298)	6
7	Other (specify):*			616									616	7
8	TOTAL General Services	(599,462)		3,810									(595,653)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			45,525									45,525	10
10a	Therapy				(37)								(37)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			7,967									7,967	15
16	TOTAL Health Care and Programs			53,492	(37)								53,455	16
	C. General Administration													
17	Administrative			(308,717)									(308,717)	17
18	Directors Fees													18
19	Professional Services	(74,122)	51,917	18,886									(3,319)	19
20	Fees, Subscriptions & Promotions	(31,891)	500	9,832									(21,559)	20
21	Clerical & General Office Expenses	(35,832)	912	40,972									6,052	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			848									848	24
25	Other Admin. Staff Transportation			13,094									13,094	25
26	Insurance-Prop.Liab.Malpractice			402									402	26
27	Other (specify):*			31,668									31,668	27
28	TOTAL General Administration	(141,846)	53,329	(193,014)									(281,531)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(741,308)	53,329	(135,713)	(37)								(823,728)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aurora Rehab & Living Center# 0040097

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	151,811	121,513										273,324	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(342,633)	70,486	3,616									(268,531)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(798,463)										(798,463)	34
35	Rent-Equipment & Vehicles			2,212									2,212	35
36	Other (specify):*													36
37	TOTAL Ownership	(190,823)	(606,464)	5,828									(791,458)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(18,140)								(18,140)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(23,107)											(23,107)	41
42	Provider Participation Fee													42
43	Other (specify):*	(88,484)											(88,484)	43
44	TOTAL Special Cost Centers	(111,591)			(18,140)								(129,731)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,043,721)	(553,135)	(129,884)	(18,177)								(1,744,918)	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		See Attached		Aurora Account LLC	Highland Park, IL	Building Company

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	\$ 798,463	Aurora Account, LLC	100.00%	\$	(798,463)	1
2	V	32 Interest	10,395	Aurora Account, LLC	100.00%	80,881	70,486	2
3	V	21 Bank Charges		Aurora Account, LLC	100.00%	629	629	3
4	V	30 Depreciation		Aurora Account, LLC	100.00%	121,513	121,513	4
5	V	19 Accounting Fees		Aurora Account, LLC	100.00%	6,645	6,645	5
6	V	19 Legal Fees		Aurora Account, LLC	100.00%	8,848	8,848	6
7	V	19 Other Profesional Fees		Aurora Account, LLC	100.00%	36,424	36,424	7
8	V	20 Franchise Taxes		Aurora Account, LLC	100.00%	500	500	8
9	V	21 Trust Fees		Aurora Account, LLC	100.00%	175	175	9
10	V	21 Miscellaneous Office		Aurora Account, LLC	100.00%	108	108	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 808,858			\$ 255,723	\$ * (553,135)	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	1		APEX HEALTHCARE SOLUTIONS LLC	100.00%	\$ 3,104	\$ 3,104
16	V	6		APEX HEALTHCARE SOLUTIONS LLC	100.00%	89	89
17	V	7		APEX HEALTHCARE SOLUTIONS LLC	100.00%	616	616
18	V	10		APEX HEALTHCARE SOLUTIONS LLC	100.00%	45,525	45,525
19	V	15		APEX HEALTHCARE SOLUTIONS LLC	100.00%	7,967	7,967
20	V	17		APEX HEALTHCARE SOLUTIONS LLC	100.00%	86,764	86,764
21	V	19		APEX HEALTHCARE SOLUTIONS LLC	100.00%	20,465	20,465
22	V	20		APEX HEALTHCARE SOLUTIONS LLC	100.00%	9,832	9,832
23	V	21		APEX HEALTHCARE SOLUTIONS LLC	100.00%	215	215
24	V	21		APEX HEALTHCARE SOLUTIONS LLC	100.00%	40,757	40,757
25	V	24		APEX HEALTHCARE SOLUTIONS LLC	100.00%	848	848
26	V	25		APEX HEALTHCARE SOLUTIONS LLC	100.00%	11,908	11,908
27	V	26		APEX HEALTHCARE SOLUTIONS LLC	100.00%	402	402
28	V	27		APEX HEALTHCARE SOLUTIONS LLC	100.00%	31,668	31,668
29	V	32		APEX HEALTHCARE SOLUTIONS LLC	100.00%	3,616	3,616
30	V	34		APEX HEALTHCARE SOLUTIONS LLC	100.00%	2,648	
31	V	35		APEX HEALTHCARE SOLUTIONS LLC	100.00%	1,718	1,718
32	V	35		APEX HEALTHCARE SOLUTIONS LLC	100.00%	495	495
33	V	17		APEX HEALTHCARE SOLUTIONS LLC	100.00%	76,464	76,464
34	V	25		APEX HEALTHCARE SOLUTIONS LLC	100.00%	1,187	1,187
35	V						
36	V	19	1,579	APEX HEALTHCARE SOLUTIONS LLC			(1,579)
37	V	17	471,945	APEX HEALTHCARE SOLUTIONS LLC	100.00%		(471,945)
38	V						
39	Total		\$ 473,524			\$ 346,288	\$ * (129,884)

* 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	\$ 825,758	Simply Rehab	100.00%	\$ 807,618	\$ (18,140)
16	V	10a Rehab Consulting	1,684	Simply Rehab	100.00%	1,647	(37)
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		\$ 827,442			\$ 809,265	\$ * (18,177)

* 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

Aurora Rehab & Living Center

0040097

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	Daniel Mann	Owner	Administrative	6.07%	See Attached	4.8	100.00%	Alloc. Salary	\$ 2,645	17-1	1
2	Aaron Mann	Owner	Administrative	6.07%	See Attached	15.3	38.25%	Alloc. Salary	76,464	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only										9
10	amounts anticipated to be considered allowable by the Illinois Department of Health & Family Services.										10
11											11
12											12
13								TOTAL	\$ 79,109		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 Aurora Rehab & Living Center

0040097

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 Aurora Rehab & Living Center

0040097

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	40,907	\$ 3,104	1
2	6	BUILDING SUPPLIES	MGMT FEES/PAT DAYS	420,185	14	917		40,907	89	2
3	7	EMP. BEN. - GENERAL	MGMT FEES/PAT DAYS	420,185	14	6,329		40,907	616	3
4	10	NURSING SALARIES	MGMT FEES/PAT DAYS	420,185	14	467,616	467,616	40,907	45,525	4
5	15	EMP. BEN, - NURSING	MGMT FEES/PAT DAYS	420,185	14	81,840		40,907	7,967	5
6	17	ADMINISTRATIVE SALARIES	MGMT FEES/PAT DAYS	420,185	14	891,211	891,211	40,907	86,764	6
7	19	PROFESSIONAL FEES	MGMT FEES/PAT DAYS	420,185	14	210,214	210,214	40,907	20,465	7
8	20	FEES, SUBSCRIPTIONS	MGMT FEES/PAT DAYS	420,185	14	100,995		40,907	9,832	8
9	21	OFFICE SALARIES	MGMT FEES/PAT DAYS	420,185	14	2,210		40,907	215	9
10	21	CLERICAL & GENERAL	MGMT FEES/PAT DAYS	420,185	14	418,647	418,647	40,907	40,757	10
11	24	SEMINARS	MGMT FEES/PAT DAYS	420,185	14	8,707		40,907	848	11
12	25	AUTO AND TRAVEL	MGMT FEES/PAT DAYS	420,185	14	122,312		40,907	11,908	12
13	26	INSURANCE	MGMT FEES/PAT DAYS	420,185	14	4,127		40,907	402	13
14	27	EMP. BEN.-GEN. ADMIN.	MGMT FEES/PAT DAYS	420,185	14	325,285		40,907	31,668	14
15	32	INTEREST	MGMT FEES/PAT DAYS	420,185	14	37,145		40,907	3,616	15
16	34	RENT	MGMT FEES/PAT DAYS	420,185	14	27,203		40,907	2,648	16
17	35	AUTO RENTAL	MGMT FEES/PAT DAYS	420,185	14	17,642		40,907	1,718	17
18	35	EQUIPMENT RENTAL	MGMT FEES/PAT DAYS	420,185	14	5,080		40,907	495	18
19	17	REGIONAL MANAGER - ILLI	DIRECT/PAT DAYS	102,486	2	191,568		40,907	76,464	19
20	25	ILLINOIS ONLY - TRAVEL	DIRECT/PAT DAYS	102,486	2	2,974		40,907	1,187	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,953,907	\$ 2,019,574		\$ 346,288	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aurora Rehab & Living Center

0040097

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					807,618	1
2	10a	Ancillary Rehab	Direct Allocation					1,647	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					\$	\$	809,265	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aurora Rehab & Living Center

0040097

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 Aurora Rehab & Living Center

0040097

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 Aurora Rehab & Living Center

0040097

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 Aurora Rehab & Living Center

0040097

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 Aurora Rehab & Living Center

0040097

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 Aurora Rehab & Living Center

0040097

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aurora Rehab & Living Center

0040097

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Aurora Rehab & Living Center

0040097

Report Period Beginning:

01/01/10

Ending:

12/31/10

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											
										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	Banco Popular		X	Mortgage				\$	\$ 378,315		\$ 80,881	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Banco Popular		X	Line of Credit							14,956	6								
7	Interest Income - Bldg. Co.		X								(10,395)	7								
8	See Supplemental Schedule										(342,589)	8								
9	TOTAL Facility Related							\$	\$ 378,315		\$ (257,147)	9								
B. Non-Facility Related*																				
10	Aurora Account	X		Line of Credit							10,395	10								
11	Venture Fund	X							1,396,726		260,309	11								
12	Interest Income		X								(45)	12								
13	See Supplemental Schedule										3,616	13								
14	TOTAL Non-Facility Related							\$	\$ 1,396,726		\$ 274,275	14								
15	TOTALS (line 9+line14)							\$	\$ 1,775,041		\$ 17,128	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Aurora Rehab & Living Center

0040097

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							\$	\$			\$	8								
9	Adjusted from Page 5A										(260,309)	9								
10	Adjusted from Page 5A										(77,320)	10								
11												11								
12	Dividend Income										(4,960)	12								
13												13								
14	TOTAL Working Capital										(342,589)	14								
	B. Non-Facility Related*																			
15	Allocated from APEX HC	X					\$	\$			\$ 3,616	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related										3,616	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.			\$	106,990	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	104,388	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,602)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	109,608	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	4,769	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	111,775	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	107,285	8	FOR BHF USE ONLY	
	2006	113,225	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$
	2007	97,458	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2008	101,895	11	15	LESS REFUND FROM LINE 6 \$
	2009	104,388	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
2010 Accrual: \$104,388 x 1.05 = \$109,608					

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aurora Rehab & Living Center

0040097

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,911 B. General Construction Type: Exterior Brick Frame _____ 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>339,768</u>	<u>1973</u>	<u>\$ 77,514</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	339,768		\$ 77,514	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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1995	8,336		20	417	417	10,265
10	Various		1996	16,977		20	849	849	12,401
11	Various		1998	35,160		20	1,758	1,758	21,542
12	Various		1999	65,009		20	3,250	3,250	38,383
13	Various		2000	24,564		20	1,228	1,228	12,829
14	Various		2001	45,347		20	2,267	2,267	21,913
15	Various		2002	1,818,858		20	91,459	91,459	785,660
16	Various		2003	458,683		20	23,816	23,816	180,492
17	Various		2004	60,861		20	6,086	6,086	39,243
18	Various		2005	93,764		20	4,688	4,688	25,637
19	Various		2006	194,574		20	12,179	12,179	52,750
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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		2,484,645	121,513			(121,513)		67
68								68
69			74,109			(74,109)		69
70		\$ 5,306,779	\$ 195,622		\$ 147,998	\$ (47,625)	\$ 1,201,115	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Aurora Rehab & Living Center# 0040097

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		\$ 5,306,779	\$ 195,622		\$ 147,998	\$ (47,625)	\$ 1,201,115	1
2	Pipe Repair - Sprinklers	2007	4,481		20	640	640	2,400	2
3	8 Valances	2007	3,255		20	326	326	1,112	3
4	Move Reception - Remodel Front Lobby	2007	3,390		20	339	339	1,356	4
5	Remodel Front Lobby & Office Area	2007	3,751		20	375	375	1,500	5
6	Aluminum Gutter & Downspouts	2007	9,500		20	950	950	3,563	6
7	Office & Lobby Remodel, Counter Reception Desk Top	2007	20,172		20	2,017	2,017	7,228	7
8	Electrical Installations	2007	3,782		20	378	378	1,292	8
9	Flooring	2007	7,014		20	701	701	2,338	9
10	Flooring	2007	5,698		20	570	570	1,947	10
11	Flooring	2007	6,933		20	693	693	2,311	11
12	Remodel Various Rooms - Drywall And Painting	2007	48,783		20	4,878	4,878	16,668	12
13	Flooring	2007	4,330		20	433	433	1,443	13
14	Repair/Additional Water Lines - Remodel	2007	13,815		20	1,382	1,382	4,605	14
15	Flooring	2007	8,362		20	836	836	2,718	15
16	Flooring	2007	30,462		20	3,046	3,046	9,646	16
17	Flooring	2007	22,100		20	2,210	2,210	6,998	17
18	Siding Soffit Material	2007	15,806		20	790	790	3,161	18
19	Canopy Repairs, Siding Tie-Ins, Metal	2007	21,280		20	1,064	1,064	4,167	19
20	Dining Room Vinyl Floor, Glass Door	2007	10,614		20	531	531	1,946	20
21	Shower Wall Tile	2007	7,779		20	389	389	1,394	21
22	Data Cabling For Network	2007	16,521		20	826	826	2,891	22
23	Replacement Glass For Door	2007	8,228		20	411	411	1,371	23
24	Entry Door, Remodeling Wing 5, Dining, Wall, Door	2007	10,567		20	528	528	1,717	24
25	Molding For Base & Doors	2007	18,927		20	946	946	2,918	25
26	Granite Countertops	2008	3,340		20	167	167	459	26
27	Code Alert Wanderer System	2008	5,165		20	258	258	603	27
28	Phone System	2008	28,455		20	1,423	1,423	3,557	28
29	Flooring & Toilets	2008	44,211		20	2,211	2,211	6,079	29
30	Service Doors	2008	2,599		20	130	130	271	30
31	Thru Wall Air Conditioners	2008	4,399		20	220	220	568	31
32	Thru Wall Air Conditioners	2008	4,399		20	220	220	660	32
33	Thru Wall Air Conditioners	2008	4,351		20	218	218	580	33
34	TOTAL (lines 1 thru 33)		\$ 5,709,247	\$ 195,622		\$ 178,104	\$ (17,518)	\$ 1,300,583	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Aurora Rehab & Living Center# 0040097

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		\$ 5,709,247	\$ 195,622		\$ 178,104	\$ (17,518)	\$ 1,300,583	1
2	Remodel Therapy & Activity Office, Wallpaper, Paint	2008	5,690		20	285	285	782	2
3	Flooring	2008	5,837		20	292	292	632	3
4	Laundry/Bathrm-Wall Work, Raise Ceiling, Electrical Work, Doo	2008	13,110		20	655	655	1,529	4
5	Sprinklers	2008	27,100		20	1,355	1,355	3,275	5
6	Condensing Unit Replacement	2008	4,289		20	214	214	518	6
7	Condensing Unit Replacement	2008	3,893		20	195	195	503	7
8	Flooring	2008	15,366		20	768	768	1,665	8
9	Drapery & Wallpaper	2008	7,350		20	368	368	1,072	9
10	Beauty Shop & Laundry Walls Lobby Stairs, Employee Lounge	2008	15,511		20	1,551	1,551	3,878	10
11	Install Vinyl Flooring In Front Lobby	2008	2,510		20	251	251	628	11
12	Boilers, Hot Water Equipment, Piping	2008	139,000		20	13,900	13,900	32,433	12
13	Flooring	2008	30,446		20	3,045	3,045	6,597	13
14	2Nd Floor Addition	2008	137,976		20	10,151	10,151	35,644	14
15	Corridor Carpet Removal	2009	4,980		20	498	498	955	15
16	8 Aluminum Fire Rated Exit Devices	2009	3,388		20	339	339	649	16
17	Wallpaper	2009	4,540		20	454	454	530	17
18	Nurse Call System	2009	24,457		20	2,446	2,446	2,853	18
19	Wall Panels And Railings	2009	13,967		20	1,397	1,397	2,793	19
20	Installation Of New Flooring	2009	23,342		20	2,334	2,334	4,668	20
21	Build Wall & Service Duct Work	2009	5,820		20	582	582	1,116	21
22	Repair Broken Pipe And Water Damage	2009	7,920		20	792	792	1,518	22
23	Replace Heat Exchanger On Hydronic Boiler	2009	3,481		20	348	348	667	23
24	Service To Floor Drains	2009	4,200		20	420	420	455	24
25	Build Out Of Wing 500	2009	13,000		20	1,300	1,300	1,408	25
26	Materials - Studs, Ceiling Panels, Caulk, Screws, Grout	2009	17,366		20	1,737	1,737	2,026	26
27	Dining Rooms & Media Room - Ceiling, Drywall, Wallpaper, Floo	2009	9,920		20	992	992	1,075	27
28	Dining/Living/Beauty Shop/Media Room - Wallpaper, Flooring, D	2009	4,606		20	461	461	499	28
29	Dining Rooms & Media Room - Wall Work, Flooring, Door, Ceilin	2009	10,180		20	1,018	1,018	1,103	29
30	Repairs To Hall Ceilings/Sprinkler System/Painting	2009	46,207		20	4,621	4,621	7,701	30
31	Repair Closets/Painting/Installation Of Door/Work To Ceilings &	2009	29,917		20	2,992	2,992	5,235	31
32	Washrooms/Offices/Dining Rooms - Fixtures, Paint, Wallpaper, Fl	2009	6,392		20	639	639	959	32
33	Dining/Office - Flooring, Wall Work, Paint, Tree Removal, Plantin	2009	16,507		20	1,651	1,651	2,338	33
34	TOTAL (lines 1 thru 33)		\$ 6,367,515	\$ 195,622		\$ 236,153	\$ 40,530	\$ 1,428,287	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Aurora Rehab & Living Center# 0040097

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		\$ 6,367,515	\$ 195,622		\$ 236,153	\$ 40,530	\$ 1,428,287	1
2	Painting Of Aluminum Siding/Repairs To Boiler Room	2009	2,623		20	262	262	350	2
3	Replace Doors	2009	8,573		20	857	857	1,286	3
4	Sprinkler Work	2009	25,000		20	2,500	2,500	4,583	4
5	Sprinkler Work	2009	39,040		20	3,904	3,904	6,507	5
6	Fire Protection Work	2009	22,493		20	2,249	2,249	4,124	6
7	Fire Protection Work	2009	3,383		20	338	338	507	7
8	Electrical Work	2009	21,327		20	2,133	2,133	2,844	8
9	Install New Wireway In Basement And Amp	2009	58,760		20	5,876	5,876	7,345	9
10	Install New Amp/New Conduits And Wire Service Entrance Main	2009	71,410		20	7,141	7,141	8,926	10
11	Hand Rails	2010	2,593		20	238	238	238	11
12	Railing	2010	38,106		20	3,493	3,493	3,493	12
13	Nurses Station Cabinets	2010	2,640		20	220	220	220	13
14	Upholstered Cornices	2010	4,185		20	349	349	349	14
15	Nurses Station	2010	11,928		20	795	795	795	15
16	Sprinkler System Reworking	2010	11,135		20	835	835	835	16
17	Physical Therapy, Bistro, Bathroom, Living & Dining	2010	29,963		20	1,998	1,998	1,998	17
18	Electrical - Therapy, Kitchen, Bathroom, Dining & Living	2010	25,318		20	1,899	1,899	1,899	18
19	6 Bathrooms And 9 Shared Baths	2010	52,675		20	3,512	3,512	3,512	19
20	Replace Walls In Resident Rooms & Corridor	2010	32,465		20	2,435	2,435	2,435	20
21	Install Telephone System	2010	2,575		20	258	258	258	21
22	Replace Hot Water Line	2010	12,185		20	812	812	812	22
23	500 Wing Walls & Bathrms- Framing,Wall Finish,Tile,Paint	2010	14,014		20	934	934	934	23
24	Electrical Work - Sump Pump, Nurses Station	2010	2,696		20	247	247	247	24
25	Electrical Work - Resident Rooms	2010	3,190		20	239	239	239	25
26	Service Radiator & Boiler	2010	3,445		20	258	258	258	26
27	Theater Room Electrical Breakers And Circuits	2010	3,115		20	286	286	286	27
28	Bistro, Dining Room Electrical Work	2010	6,510		20	597	597	597	28
29	Wireway, Relocate Sprinkler Line And Smoke Det. Conduit	2010	5,039		20	462	462	462	29
30	Generator Load Center	2010	19,513		20	1,789	1,789	1,789	30
31	Fire System Repairs	2010	3,343		20	279	279	279	31
32	Install New Grease Interceptor And Sewer Lines	2010	20,000		20	1,000	1,000	1,000	32
33	Re-Route Interior Grease Waste	2010	12,435		20	622	622	662	33
34	TOTAL (lines 1 thru 33)		\$ 6,939,192	\$ 195,622		\$ 284,968	\$ 89,346	\$ 1,488,354	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 12D, Carried Forward		\$ 6,939,192	\$ 195,622		\$ 284,968	\$ 89,346	\$ 1,488,354	1
2	500 Wing Bathrooms-Pipe Wrk,New Fixtures,Valves,Showers	2010	70,940		20	3,547	3,547	3,547	2
3	Rework Hvac & Exhaust Duct In 500 Wing Rooms	2010	6,480		20	324	324	324	3
4	Remodel, Repairs To Wireless Nurse Call System	2010	3,950		20	198	198	198	4
5	Inspect & Repair Grease Basin And Sewer Installation	2010	5,855		20	293	293	293	5
6	Patio & Fence Post Repairs	2010	3,434		20	172	172	172	6
7	Asphalt Patching, Dumpster Pad Work, Patio, Walkways, Fence I	2010	13,571		20	679	679	679	7
8	Sink Protectors, Repairs From State Inspection Of 500 Wing	2010	2,844		20	142	142	142	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,046,266	\$ 195,622		\$ 290,322	\$ 94,700	\$ 1,493,709	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Aurora Rehab & Living Center

0040097

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	Building Company Information								1
2	Buildings:								2
3	Aurora Account LLC	1962	973,690		35				3
4	Aurora Account LLC	1976	637,909	121,513	35	(121,513)			4
5	Aurora Account LLC	1983	35,661		35				5
6	Aurora Account LLC	1984	9,486		35				6
7	Aurora Account LLC	1985	2,338		35				7
8	Leasehold Improvements:								8
9	Various	1994	67,225		20				9
10	Various	1993	10,887		20				10
11	Various	1992	4,332		20				11
12	Various	1991	39,929		20				12
13	Various	1990	137,077		20				13
14	Various	1988	10,040		20				14
15	Various	1987	106,312		20				15
16	Various	1986	236,734		20				16
17	Various	1985	25,102		20				17
18	Various	1984	22,377		20				18
19	Various	1983	10,020		20				19
20	Various	1982	49,137		20				20
21	Various	1981	4,175		20				21
22	Various	1980	31,412		20				22
23	Various	1979	35,255		20				23
24	Various	1978	16,968		20				24
25	Various	1977	16,093		20				25
26	Various	1973	2,486		20				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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,484,645	\$ 121,513		\$	\$ (121,513)	\$

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 Aurora Rehab & Living Center

0040097

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	\$ 536,613	\$	\$ 55,312	\$ 55,312	10	\$ 279,145	71
72	Current Year Purchases	17,989		1,799	1,799	10	1,799	72
73	Fully Depreciated Assets	217,948				10	217,948	73
74								74
75	TOTALS	\$ 772,550	\$	\$ 57,111	\$ 57,111		\$ 498,891	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		Truck	1998	\$ 16,564	\$	\$	\$	5	\$ 16,563	76
77		Bus	1999	68,151				5	68,151	77
78										78
79										79
80	TOTALS			\$ 84,715	\$	\$	\$		\$ 84,714	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,981,044	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 195,622	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 347,433	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 151,811	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,077,315	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: \$ 13,609 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 Healthcare Solutions LLC</u>		\$ _____	\$ <u>1,718</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>1,718</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		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	329,326	\$		\$	329,326	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				131,128				131,128	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				372,358				372,358	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					190,005			190,005	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>						14,233	68,179			82,412	13
14	TOTAL			\$		\$	847,045	\$	258,184	\$	1,105,229	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 Aurora Rehab & Living Center# 0040097Report 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	\$ 594,802	\$ 659,471	1
2	Cash-Patient Deposits	1,650	1,650	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	482,213	482,213	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,560	7,560	6
7	Other Prepaid Expenses	5,796	5,796	7
8	Accounts Receivable (owners or related parties)	37,107	37,107	8
9	Other(specify): <u>See Attached Schedule</u>	274,552	274,552	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,403,680	\$ 1,468,349	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		77,514	13
14	Buildings, at Historical Cost		1,611,598	14
15	Leasehold Improvements, at Historical Cost	946,441	4,288,037	15
16	Equipment, at Historical Cost	429,492	429,492	16
17	Accumulated Depreciation (book methods)	(639,504)	(2,982,289)	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>		681,730	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 736,429	\$ 4,106,082	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,140,109	\$ 5,574,431	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,448,212	\$ 1,448,213	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,717	143,717	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,688	18,688	31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,608	109,608	32
33	Accrued Interest Payable		(65,000)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	4,838,590	5,007,517	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,558,815	\$ 6,662,743	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,396,726	39
40	Mortgage Payable		378,315	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)	\$	\$ 1,775,041	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,558,815	\$ 8,437,784	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,418,706)	\$ (2,863,353)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,140,109	\$ 5,574,431	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,665,498)	1
2	Restatements (describe):		2
3	<u>Adjusting Entry</u>	3,808	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,661,690)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,757,016)	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)	\$ (1,757,016)	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)	\$ (4,418,706)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Aurora Rehab & Living Center**# **0040097**Report Period Beginning: **01/01/10**Ending: **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	\$ 6,016,379	1
2	Discounts and Allowances for all Levels	469,624	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,486,003	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,481,115	6
7	Oxygen	35,502	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,516,617	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	23,107	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	326,886	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,886	19
20	Radiology and X-Ray	6,575	20
21	Other Medical Services	11,069	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 386,523	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,005	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,005	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	38,278	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,278	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,432,426	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,319,269	31
32	Health Care	3,207,387	32
33	General Administration	2,048,273	33
B. Capital Expense			
34	Ownership	1,278,349	34
C. Ancillary Expense			
35	Special Cost Centers	1,233,564	35
36	Provider Participation Fee	102,600	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,189,442	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,757,016)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,757,016)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 **Aurora Rehab & Living Center**

0040097

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	2,035	2,084	\$ 103,369	\$ 49.60	1
2	Assistant Director of Nursing	1,299	1,378	45,505	33.02	2
3	Registered Nurses	26,541	28,148	929,599	33.03	3
4	Licensed Practical Nurses	18,995	20,092	571,294	28.43	4
5	CNAs & Orderlies	76,359	80,870	975,636	12.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,673	9,705	139,266	14.35	8
9	Activity Director	1,793	2,083	32,153	15.44	9
10	Activity Assistants	8,765	9,199	96,266	10.46	10
11	Social Service Workers	2,735	2,898	57,540	19.86	11
12	Dietician					12
13	Food Service Supervisor	1,566	1,663	41,871	25.18	13
14	Head Cook	3,349	3,867	54,781	14.17	14
15	Cook Helpers/Assistants	23,101	25,351	249,455	9.84	15
16	Dishwashers					16
17	Maintenance Workers	4,648	4,992	106,125	21.26	17
18	Housekeepers	18,865	20,311	202,504	9.97	18
19	Laundry	5,797	6,241	62,098	9.95	19
20	Administrator	1,632	1,682	86,341	51.33	20
21	Assistant Administrator	251	251	2,645	10.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,964	15,096	218,942	14.50	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	2,074	2,172	42,173	19.42	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,236	5,961	137,138	23.00	33
34	TOTAL (lines 1 - 33)	227,678	244,044	\$ 4,154,701 *	\$ 17.02	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	292	\$ 13,118	01-03	35
36	Medical Director	Monthly	37,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	One time fee	644	10-03	39
40	Physical Therapy Consultant	6	389	10a-03	40
41	Occupational Therapy Consultant	7	434	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	0	27	10a-03	43
44	Activity Consultant	94	6,024	11-03	44
45	Social Service Consultant	72	5,108	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	\$ 62,744		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	
Bill Pfeiffer	Administrator		\$ 86,341	Workers' Compensation Insurance	\$ 81,111	IDPH License Fee	\$	
Daniel Mann	Asst. Admin	6.07	2,645	Unemployment Compensation Insurance	63,557	Advertising: Employee Recruitment		
				FICA Taxes	312,316	Health Care Worker Background Check	1,250	
				Employee Health Insurance	258,778	(Indicate # of checks performed <u>125</u>)		
				Employee Meals		Patient Background Checks	208 2,080	
				Illinois Municipal Retirement Fund (IMRF)*		Dues	45	
				401k Matching Expense	9,097	Licenses, Inspections & Fees	9,167	
				Other Employee Benefits	9,557	Allocated from APEX Healthcare	9,832	
				Union Pension Expense	67,468			
				Supplemental Insurance	3,887			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,986	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 805,771		\$ 22,374		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - APEX Healthcare			\$ 471,945				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 471,945				Seminar Expense	1,972
							Allocated from APEX Healthcare	848
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,820
C. Professional Services				TOTAL				
Vendor/Payee	Type	Amount						
Frost, Ruttenberg & Rothblatt	Accounting	\$ 24,000						
Camille Koehl	Accounting	12,104						
American Data	Computer Services	4,475						
CDW	Computer Services	991						
HDSI	Computer Services	6,119						
APEX Healthcare Solutions LLC	Computer Services	1,579						
IVANS, Inc.	Computer Services	3,448						
Scott Lankford	Computer Services	318						
Personnel Planners	Unemployment Consulting	2,164						
FEI Architects	Architectural	13,614						
Olympic Engineering	Engineering	2,500						
See Supplemental Schedule		97,936						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 169,247	\$				

* 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 Aurora Rehab & Living Center# 0040097

Report Period Beginning:

01/01/10

Ending:

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. N/A
- (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? N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,512 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 102,600
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. \$ N/A Has any meal income been offset against related costs? N/A 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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.