

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 003-6244

Facility Name: Alden Princeton Rehabilitation and Health Care Center, Inc.

Address: 255 W. 69th Street Chicago 60621
Number City Zip Code

County: Cook

Telephone Number: (773) 224-5900 Fax #: (773) 224-7157

HFS ID Number:

Date of Initial License for Current Owners: 08/24/90

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

X

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll Telephone Number: (773) 724-6622
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Joan Carl

(Title) Vice-President

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc.

003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 _____

	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	225	Skilled (SNF)	225	82,125	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less		0	6
7	225	TOTALS	225	82,125	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,465	815	4,078	14,358	8
9	SNF/PED					9
10	ICF	43,081	173	238	43,492	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,546	988	4,316	57,850	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.44%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/90 NO ☐

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

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Princeton Rehabilitation and Health C # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	299,226	23,353	22,800	345,379		345,379		345,379			1
2	Food Purchase		396,298		396,298		396,298		396,298			2
3	Housekeeping	267,875	58,470		326,345		326,345		326,345			3
4	Laundry	50,127	25,406	327	75,860		75,860		75,860			4
5	Heat and Other Utilities			219,449	219,449		219,449		219,449			5
6	Maintenance	41,110		215,687	256,797		256,797		256,797			6
7	Other (specify):* Related party											7
8	TOTAL General Services	658,338	503,527	458,263	1,620,128		1,620,128		1,620,128			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	2,520,363	200,919	20,239	2,741,521		2,741,521		2,741,521			10
10a	Therapy	78,377	413	11,788	90,578		90,578		90,578			10a
11	Activities	388,546	15,103	11,251	414,900		414,900		414,900			11
12	Social Services	39,497			39,497		39,497		39,497			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related party											15
16	TOTAL Health Care and Programs	3,026,783	216,435	76,278	3,319,496		3,319,496		3,319,496			16
	C. General Administration											
17	Administrative	140,869			140,869		140,869		140,869			17
18	Directors Fees											18
19	Professional Services			751,326	751,326		751,326	7,255	758,581			19
20	Dues, Fees, Subscriptions & Promotions			119,435	119,435		119,435		119,435			20
21	Clerical & General Office Expenses	183,913	24,960	76,091	284,964		284,964		284,964			21
22	Employee Benefits & Payroll Taxes			889,786	889,786		889,786		889,786			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,345	6,345		6,345		6,345			24
25	Other Admin. Staff Transportation			1,393	1,393		1,393		1,393			25
26	Insurance-Prop.Liab.Malpractice			239,767	239,767		239,767	6,921	246,688			26
27	Other (specify):* Related party			121,463	121,463		121,463		121,463			27
28	TOTAL General Administration	324,782	24,960	2,205,606	2,555,348		2,555,348	14,176	2,569,524			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,009,903	744,922	2,740,147	7,494,972		7,494,972	14,176	7,509,148			29

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

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

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			83,855	83,855		83,855	290,724	374,579			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			149,067	149,067		149,067	396,632	545,699			32
33	Real Estate Taxes			274,000	274,000		274,000	273,264	547,264			33
34	Rent-Facility & Grounds			509,235	509,235		509,235	(783,235)	(274,000)			34
35	Rent-Equipment & Vehicles			16,106	16,106		16,106		16,106			35
36	Other (specify):*							188,958	188,958			36
37	TOTAL Ownership			1,032,263	1,032,263		1,032,263	366,343	1,398,606			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		257,984	320,885	578,869		578,869		578,869			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				123,188		123,188		123,188			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		257,984	320,885	702,057		702,057		702,057			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,009,903	1,002,906	4,093,295	9,229,292		9,229,292	380,519	9,609,811			45

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

Reclassifications - Pages 3 & 4, Column 5

From Line	To Line	Amount	Description
2	22		Employee Meals Employee Meals
22	10		Uniforms
	1		Uniforms
	3		Uniforms
	4		Uniforms
	6		Uniforms
	11		Uniforms
	21		Uniforms
10	39		Oxygen - to appropriate cost center Oxygen - to appropriate cost center
33	34		Rent - Real Estate Tax on associated landowner (Pg 6) Rent - Real Estate Tax on associated landowner (Pg 6)
19	33		Reclass from Professional Fees to Real Estate tax Reclass from Professional Fees to Real Estate tax
21			Vendor Settlements Vendor Settlements (may effect more than one line)
Others, if any:			
19	10		Clinical Coordinators (Pathway Billing) Clinical Coordinators (Pathway Billing)
19	21		MediFax/MedCom MediFax/MedCom
Net		-	

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY							
48		49		50		51	

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 Amount	2 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)	380,524	Various	34
35	Other- Attach Schedule		Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 380,524		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 380,524		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#003-6244

Report Period Beginning:1/1/2011

Ending:12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$	301
2	Elim Deprec Exp on Pg 13 items under \$2500 -		302
3	Expense Pg 12 items under \$2,500 - curr yr purchs +		63
4	Expense Pg 13 items under \$2,500 - curr yr purchs +		64
5			5
6	Elim ABC Deprec Exp from Pg 12 series -		306
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc# 003-6244

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,255	0	0	0	0	0	0	0	0	0	7,255	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,921	0	0	0	0	0	0	0	0	0	6,921	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	14,176	0	0	0	0	0	0	0	0	0	14,176	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	14,176	0	0	0	0	0	0	0	0	0	14,176	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	0	290,724	0	0	0	0	0	0	0	0	0	290,724	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	396,632	0	0	0	0	0	0	0	0	0	396,632	32
33	Real Estate Taxes	0	273,264	0	0	0	0	0	0	0	0	0	273,264	33
34	Rent-Facility & Grounds	0	(783,235)	0	0	0	0	0	0	0	0	0	(783,235)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	188,958	0	0	0	0	0	0	0	0	0	188,958	36
37	TOTAL Ownership	0	366,343	0	0	0	0	0	0	0	0	0	366,343	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	380,519	0	0	0	0	0	0	0	0	0	380,519	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group, Ltd.	100%	See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 783,235	Princeton Associates I L.L.C.	0.00%	\$	\$ (783,235)	1
2	V	32	Investment Income RR	1,068	Princeton Associates I L.L.C.			(1,068)	2
3	V	19	Accounting Fees		Princeton Associates I L.L.C.		7,005	7,005	3
4	V	33	Real Estate Tax		Princeton Associates I L.L.C.		273,264	273,264	4
5	V	26	Property & Liability Insurance		Princeton Associates I L.L.C.		6,921	6,921	5
6	V	32	Interest on Mortgage Note		Princeton Associates I L.L.C.		340,116	340,116	6
7	V	32	Interest on Operating Loss Loan		Princeton Associates I L.L.C.		10,729	10,729	7
8	V	36	Mortgage Insurance Premium		Princeton Associates I L.L.C.		41,671	41,671	8
9	V	30	Depreciation		Princeton Associates I L.L.C.		290,724	290,724	9
10	V	32	Amortization		Princeton Associates I L.L.C.		46,855	46,855	10
11	V	21	Misc Administrative Expenses		Princeton Associates I L.L.C.				11
12	V	19	Professional Fees		Princeton Associates I L.L.C.		250	250	12
13	V	36	Prepayment Penalty		Princeton Associates I L.L.C.		147,287	147,287	13
14	Total			\$ 784,303			\$ 1,164,822	\$ * 380,519	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			\$	Alden Management Services, Inc.	0.00%	\$ 1	\$ 1	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			\$			\$ 1	\$ *	1 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			\$	Prism Health Care Services, Inc.	0.00%	\$ 1	\$ 1	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			\$			\$ 1	\$ *	1 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			\$	Forum Extended Care Services II, Inc.	0.00%	\$ 1	\$ 1	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			\$			\$ 1	\$ *	1 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			\$	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1	\$ 1	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			\$			\$ 1	\$ *	1 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			\$	Alden Bennett Construction Company, Inc.	0.00%	\$ 1	\$ 1	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			\$			\$ 1	\$ *	1 39

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

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc. # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Home Office rental	2
3			Alden-Long Grove Rehabilitation and Health Car Long Grove					3
4			Alden-Lincoln Park Rehabilitation and Health Ca Chicago		Forum Extended Care Se	Chicago	Pharmacy	4
5			Alden-Northmoor Rehabilitation and Health Care Chicago		Alden Management Serv	Chicago	Management	5
6			Alden-Lakeland Rehabilitation and Health Care (Chicago					6
7			Alden of Old Town East, Inc.	Bloomingtondale	Alden Gardens of Bloomi	Bloomingtondale	Supportive Living Fac	7
8			Alden Terrace of McHenry Rehabilitation and He McHenry		Alden Garden Courts of	DesPlaines	Assisted Living/Alzhei	8
9			Alden - Wentworth Rehabilitation and Health Cai Chicago		Alden Courts of Waterfo	Aurora	Alzheimers Facility	9
10			Alden Estates of Naperville, Inc.	Naperville	Alden Gardens of Waterf	Aurora	Assisted Living	10
11			Alden - Valley Ridge Rehabilitation and Health C Bloomingtondale		Prism Health Care Servi	Schaumburg	Nursing and Durable I	11
12			Alden Village Health Facility for Children and Yo Bloomingtondale		Community Physical The	Addison	Therapy Provider	12
13			Alden - Orland Park Rehabilitation and Health C: Orland Park		Alden Bennett Construct	Chicago	General Contractor	13
14			Alden - Princeton Rehabilitation and Health Car Chicago		Fort Medical Equipment	Fort Atkinson, WI	Nursing and Durable I	14
15			Alden of Old Town West, Inc.	Bloomingtondale	Fort Healthcare, LLC	Fort Atkinson, WI	SNF w/in hospital	15
16			Alden - Town Manor Rehabilitation and Health C Cicero					16
17			Alden Trails, Inc.	Bloomingtondale				17
18			Alden - Poplar Creek Rehabilitation and Health C Hoffman Estates					18
19			Alden - North Shore Rehabilitation and Health C: Skokie					19
20			Alden - Des Plaines Rehabilitation and Health C: Des Plaines					20
21			Alden Estates of Evanston, Inc.	Evanston				21
22			Alden - Alma Nelson Manor, Inc.	Rockford				22
23			Alden - Park Strathmoor, Inc.	Rockford				23
24			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				24
25			Alden Estates of Barrington, Inc.	Barrington				25
26			Alden of Waterford, LLC	Aurora				26
27			Alden Springs, Inc.	Bloomingtondale				27
28			Alden Village North, Inc.	Chicago				28
29			Alden Estates of Skokie, Inc.	Skokie				29
30			Alden Estates of Countryside, Inc.	Jefferson, WI				30

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	Floyd A. Schlossberg	President	CEO	100.00				Salary	\$	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00				Salary		10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00				Salary		6-7	3
4											4
5											5
6											6
7	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										8
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers.										9
10											10
11											11
12											12
13								TOTAL	\$		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**

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, I # 003-6244 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Alden Management Services, Inc.
Street Address 4200 W. Peterson
City / State / Zip Code Chicago, IL 60646
Phone Number (773-724-6622
Fax Number (773-724-6622

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

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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Related party-AMS		x	Working Capital									6
7	Related party-FECII		x	Working Capital									7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # 36

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

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

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

[illegible]

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Alden Princeton Rehabilitation and Health Care Center, Inc.

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

003-6244

CONTACT PERSON REGARDING THIS REPORT

Steven M. Kroll

TELEPHONE

(773) 724-6622

FAX #:

(773-283-3997

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. <u>See attached supplement</u>	<u>Related Party-Alden Management Ser</u>	\$ <u> </u>	\$ <u> </u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	\$ <u> </u>	\$ <u> </u>
3. <u>20-21-413-001-0000</u>	<u>Nursing Home Facility</u>	\$ <u>15,202.08</u>	\$ <u>15,202.08</u>
4. <u>20-21-413-002-0000</u>	<u>Nursing Home Facility</u>	\$ <u>13,587.03</u>	\$ <u>13,587.03</u>
5. <u>20-21-413-003-0000</u>	<u>Nursing Home Facility</u>	\$ <u>51,724.12</u>	\$ <u>51,724.12</u>
6. <u>20-21-413-004-0000</u>	<u>Nursing Home Facility</u>	\$ <u>76,546.03</u>	\$ <u>76,546.03</u>
7. <u>20-21-413-005-0000</u>	<u>Nursing Home Facility</u>	\$ <u>14,066.12</u>	\$ <u>14,066.12</u>
8. <u>20-21-413-022-0000</u>	<u>Nursing Home Facility</u>	\$ <u>13,490.87</u>	\$ <u>13,490.87</u>
9. <u>20-21-413-032-0000</u>	<u>Nursing Home Facility</u>	\$ <u>791.97</u>	\$ <u>791.97</u>
10. <u>20-21-413-035-0000</u>	<u>Nursing Home Facility</u>	\$ <u>76,515.95</u>	\$ <u>76,515.95</u>
TOTALS		\$ <u><u>261,924.17</u></u>	\$ <u><u>261,924.17</u></u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 80,000

B. General Construction Type: Exterior brick Frame steel Number of Stories 3
- 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).

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
- ☐ YES
- ☒ NO
- If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:
- Nature of Costs:
- (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing facility	66,775	1991	\$ 1,137,260	1
2					2
3	TOTALS	66,775		\$ 1,137,260	3

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc. # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	225		1990	1989	6,937,625	220,767	30	231,254	10,487	4,740,707	4
5											5
6			1992	1992	44,020	280	30	1,467	1,187	27,015	6
7			1993	1993	30,616	692	30	1,021	329	18,645	7
8											8
	Improvement Type**										
9	FLOORING/PUMP SWITCH/FREEZER MOTOR/MISC			1991	7,180		VARIOUS			7,180	9
10	EXHAUST PARTS/BOILER REPAIRS/PIPE INSUL/VALVE/FAUCET/			1992	10,511		VARIOUS			10,511	10
11	WALL PAINT/CARPETING/BASE/MOTOR/PUMP/DOOR/COMPRES			1993	24,066		VARIOUS			24,066	11
12	DOOR/HEATING COIL/VBOILER VALVE/WATER TANK/EXTINGU			1995	27,107	1,431	VARIOUS	1,431		24,651	12
13	NEW CARPETING			1996	1,400		10			1,400	13
14	COIL REPLACEMENT(AIR CONDITIONER)			1996	4,821		10			4,821	14
15	CEILING REPAIRS			1996	1,700		12			1,700	15
16	INSTALL SB 35 PUMP			1997	3,287		10			3,287	16
17	SEAL COATING/PATCHING			1997	2,300		5			2,300	17
18	REPAIR KEBO LIFT			1997	1,917		5			1,917	18
19	LONG ELEV(INSTALL GATE RESTRICTOR-ELEV)			1998	6,800		10			6,800	19
20	SHINE-RITE(STRIP & REFINISH FLOORS)			1998	6,000		10			6,000	20
21	CORONET MFG			1998	8,970		10			8,970	21
22	REEDY EQ.(REPAIR DISHWASHERS)			1998	4,612		10			4,612	22
23	JP Graham(installation)			1999	2,781		10			2,781	23
24	Northtown (repair steamer)			1999	1,674		10			1,674	24
25	Rykoff Sexton(kitchen supplies)			1999	2,337		10			2,337	25
26	Long Elevator(repair water damage)			1999	2,949		10			2,949	26
27	Fox Valley(fire alarm inspection)			1999	2,000	133	15	133		1,487	27
28	ABC(construction management)			1999	785		5			785	28
29	Kraft Paper (desk & chairs)			1999	2,023	135	15	135		1,495	29
30	Climate Services(exhaust roof top repair)			1999	2,143		10			2,143	30
31	New Horizons(install phones and wall mounts)			1999	5,848		10			5,848	31
32	ABC:Carpentry labor			1999	2,460		10			2,460	32
33	ABC:Resilient flooring			1999	3,996		10			3,996	33
34	Equipment International (dryer fan blade)			2000	602	6	10	6		602	34
35	CSI-Coker Service (repair steam table)			2000	1,151	10	10	10		1,151	35
36	Fox Valley(fire alarm inspection)			2000	776	5	10	5		776	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc. # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 Equipment International (motor repair - washer)	2000	\$ 1,106	\$ 8	10	\$ 8		\$ 1,106	37
38 Climate Service (replace hot water valve)	2000	1,303	12	10	12		1,303	38
39 Kraft Paper Sales Co. (HP 175 RPM)	2000	1,051	18	10	18		1,051	39
40 DePaul Plumbing (instal water line of outside sprinkler system)	2000	7,054	178	10	178		7,054	40
41 Alden Bennett Construction (time & material billing by facility)	2000	11,158	557	10	557		11,158	41
42 Fox Valley Fire & Safety (rep faulty devices from fire alarm)	2000	1,672	111	15	111		1,159	42
43 SKI-COKER SERVICE (dishwasher repair)	2000	1,834	93	10	93		1,834	43
44 Alden Bennett Construction (time & material billing)	2000	7,777	517	10	517		7,777	44
45 Fox Valley (fire alarm repair)	2000	2,338	194	10	194		2,338	45
46 ALDEN DESIGN (oxygen site plan)	2000	663	40	10	40		663	46
47 ALDEN DESIGN (oxygen site plan)	2000	357	20	10	20		357	47
48 ALDEN DESIGN (install medical gas system)	2000	1,540	90	10	90		1,540	48
49 ALDEN DESIGN (plat of survey)	2000	756	55	10	55		756	49
50 Alden Bennett Construction (oxygen tank installation)	2001	23,815	2,382	10	2,382		22,428	50
51 Alden Bennett Construction (lighting fixtures)	2001	63,680	6,368	10	6,368		62,619	51
52 New Horizons Communication (No Invoice)	2001	6,287	628	10	628		6,287	52
53 GT Mechanical Inc (exhaust fan in laundry room)	2001	2,475	165	15	165		1,650	53
54 CSI-Corker Service Inc(new Boiler installed)	2001	4,713	236	20	236		2,319	54
55 System Electric,Inc(Installed circuits & receptacles)	2001	1,852	93	20	93		897	55
56 Equipment Int'l (washer repair)	2001	1,110		5			1,110	56
57 GT Mechanical Inc (repair freezer)	2001	2,886		5			2,886	57
58 Alden Bennett (miscell construction)	2001	2,913	291	10	291		2,814	58
59 Hobart (installed amps for serving steamers)	2001	1,828		5			1,828	59
60 Capps (install preassure reading valve)	2001	3,485	349	10	349		3,197	60
61 Fire Pros (control panel repair)	2001	5,425		10			5,425	61
62 Alden Bennett (miscell construction)	2001	2,876	288	10	288		2,662	62
63 Alden Bennett (miscell construction)	2001	1,622		5			1,622	63
64 Fire Pros (control panel repair)	2002	5,425	543	10	543		4,885	64
65 Alden bennet -- window sills	2002	8,139	814	10	814		7,122	65
66 GT Mechincal -- repair chiller	2002	3,449		5			3,449	66
67 Alden bennet - nursing call system install	2002	23,320	1,555	15	1,555		12,957	67
68 Simplex Grinnell (4 doors)	2003	4,391	439	10	439		3,476	68
69 Alden Bennett Construction (time & material billing by facility)	2003	20,159	2,016	10	2,016		15,960	69
70 TOTAL (lines 4 thru 69)		\$ 7,382,913	\$ 241,517		\$ 253,520	\$ 12,003	\$ 5,128,755	70

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

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc. # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 Totals from Page 12A, Carried Forward		\$ 7,382,913	\$ 241,517		\$ 253,520	\$ 12,003	\$ 5,128,755	1
2 D. B. S. Contracting (sprinkler system)	2003	15,935		3			15,935	2
3 Alden Bennett Construction (lamps)	2003	3,339	334	10	334		2,449	3
4 TNS Inc (DSL Cable)	2004	1,178		5			1,178	4
5 Alden Bennett Const (curries flat bar,fire rated access panel)	2004	1,229		5			1,229	5
6 Alden Bennett Const (installed fire damper)	2004	2,628	263	10	263		1,775	6
7 Alden Bennett Const (bathroom floors)	2004	3,945	395	10	395		2,402	7
8 Alden Bennett Construction (Boiler reparis)	2004	2,746		5			2,746	8
9 GT Mechanical (Heater repairs-coil replacement)	2004	5,821	582	10	582		4,074	9
10 GT Mechanical (Blower motor and fan coil replaced)	2004	1,489	149	10	149		1,043	10
11 GT Mechanical (Fan coil replacement)	2004	746	75	10	75		518	11
12 CSI Coker Service (steamer, food processor, coffee ura repairs)	2004	1,948		5			1,948	12
13 GT Mechanical (air controler,thermostat,switches replaced)	2004	1,966		10			1,966	13
14 Long Elevator (replaced car button, single phase rectifier)	2004	1,800		5			1,800	14
15 GT Mechanical - chiller	2004			5			1,628	15
16 Patten CAT (Generator repairs) (AMS Billings)	2004	2,660		5			2,660	16
17 Patten CAT (Generator repairs) (AMS Billings)	2004	1,594		5			1,594	17
18 Equipment International (Dryer repairs)	2004	2,950		5			2,950	18
19 Capps Plumbing (Sink & Boiler repairs)	2004	1,865		5			1,865	19
20 Alden Bennett (27-Thermal Units-Furnished & Installed)	2005	5,716	381	15	381		2,667	20
21 BROLOC Brolin Lock And Safe	2005	3,855	386	10	386		2,187	21
22 Patten CAT (0105 AMS Billings)(Vehicle Air Induct & Exhaust Sys	2005	1,986		5			1,986	22
23 GT Mechanical (Wiring,Fan Coil Replacement, Valve repairs)	2005	1,763	28	5	28		1,763	23
24 GT Mechanical (Rooftop exhaust Fan belt repairs)	2005	2,409	80	5	80		2,409	24
25 GT Mechanical (A/H 3 repairs)	2005	1,556	79	5	79		1,556	25
26 Patten CAT (0705 AMS Billings)(Remove and Install transfer switch	2005	10,964	1,096	5	1,096		10,964	26
27 ABC (Roof Repairs)	2005	2,511	294	5	294		2,511	27
28 Brolin Locks and Safe (cylinders, entry levers)	2006	4,134	827	5	827		3,308	28
29 ABC (new pump alternator)	2006	5,438	1,088	5	1,088		4,352	29
30 GT Mechanical (cooling tower, IO board, condenser)	2006	2,724		5			2,724	30
31 GT Mechanical (cooling tower, IO board, condenser)	2006						6,376	31
32 ABC - AC compressor	2006						3,643	32
33 ABC (repair supplies, paint,surface cap)	2006	3,199	640	5	640		2,080	33
34 TOTAL (lines 1 thru 33)		\$ 7,483,008	\$ 248,214		\$ 260,217	\$ 12,003	\$ 5,227,041	34

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

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc. # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 Totals from Page 12B, Carried Forward		\$ 7,483,008	\$ 248,214		\$ 260,217	\$ 12,003	\$ 5,227,041	1
2 <u>ABC (new transformer)</u>	2006	8,185	819	10	819		2,566	2
3 <u>ABC (new compressor)</u>	2006	21,154	2,115	10	2,115		8,989	3
4 <u>ABC (exhaust fan)</u>	2006	2,801	560	5	560		2,333	4
5 <u>A&B Custom Cable (install cable TV system)</u>	2006	13,500	1,350	10	1,350		5,400	5
6 <u>Fence</u>	2007	2,813	281	10	281		984	6
7 <u>ABC - paint facility</u>	2007	2,589	259	10	259		1,014	7
8 <u>ABC - electrical security system</u>	2007	13,341	1,334	10	1,334		5,124	8
9 <u>TopNotch - 2HP motor</u>	2007	2,909	291	10	291		1,115	9
10 <u>GT Mech - air compressor</u>	2007			5			3,360	10
11 <u>ABC - bathroom vinyl sheet flooring</u>	2007	4,305	431	10	431		1,544	11
12 <u>ABC - HVAC</u>	2007			10			6,000	12
13 <u>ABC - new doors (exit and kitchen)</u>	2007	3,183	318	10	318		1,087	13
14 <u>ABC - new parts HVAC motor</u>	2007			10			4,882	14
15 <u>ABC - temp a/c</u>	2007	10,135	2,027	5	2,027		6,757	15
16 <u>New plumbing fixtures, electrical appliances</u>	2007	4,091	818	5	818		2,522	16
17 <u>New tiles, fixtures/window</u>	2008	3,478	348	10	348		928	17
18 <u>New sewage injector pump</u>	2008	6,619	662	10	662		1,710	18
19 <u>Replaced ceiling tiles</u>	2008	2,927	293	10	293		659	19
20 <u>Repair hvac 3 way valve</u>	2008			10			4,518	20
21 <u>New sewer line</u>	2008	3,500	140	25	140		292	21
22 <u>ABC - front entrance ramp oxygen transfilling pad</u>	2009	5,123	256	20	256		314	22
23 <u>ABC - ramp concrete at the entrance</u>	2009	12,763	851	15	851		1,064	23
24 <u>ABC - parking lot wall protection</u>	2009	4,887	489	10	489		611	24
25 <u>GT Mechanical - boiler #2 repairs</u>	2009	7,016	1,403	5	1,403		2,689	25
26 <u>ABC - replacement HVAC room coils</u>	2009	3,975	795	5	795		861	26
27 <u>GT Mechanical - heat exchanger</u>	2009	3,529	706	5	706		1,294	27
28 <u>ABC - replacement laundry door</u>	2009	3,292	658	5	658		1,097	28
29 <u>ABC - plumbing for hot water storage tank</u>	2009	10,116	674	15	674		730	29
30 <u>GT Mechanical - coil piping insulation</u>	2009	12,656	2,531	5	2,531		3,586	30
31 <u>Cable Satellite - outlets wiring</u>	2009	6,800	680	10	680		907	31
32 <u>GT Mechanical - cooling tower</u>	2009	2,631	526	5	526		570	32
33								33
34 TOTAL (lines 1 thru 33)		\$ 7,661,324	\$ 269,830		\$ 281,833	\$ 12,003	\$ 5,302,548	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Totals from Page 12C, Carried Forward		\$ 7,661,324	\$ 269,830		\$ 281,833	\$ 12,003	\$ 5,302,548	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,661,324	\$ 269,830		\$ 281,833	\$ 12,003	\$ 5,302,548	34

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

XL OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Totals from Page 12D, Carried Forward		\$ 7,661,324	\$ 269,830		\$ 281,833	\$ 12,003	\$ 5,302,548	1
2	ABC - broken HVAC motor repairs	2009	2,742	548	5	548		731	2
3	Chiller-2009	2009	274,071	18,271		18,271		22,839	3
4	ABC - tuckpointing entire o/s of building	2010	209,080	2,613	20	2,613		2,613	4
5	ABC - new windows	2010	2,725	250	10	250		250	5
6	ABC - new windows	2010	8,136	610	10	610		610	6
7	ABC - new windows	2010	20,306		10				7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,178,384	\$ 292,123		\$ 304,126	\$ 12,003	\$ 5,329,591	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 9,315,644	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 292,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 304,126	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,003	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,329,591	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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: \$ Description: (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	related party- Pg 6A	various	\$ 0.00	\$	17
18					18
19	Auto lease GL 6890	various	0.00		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☒ NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. Skilled nursing on site	2. CLASSROOM PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER CNA	3. CLINICAL PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY HOURS PER CNA
---	---	---

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-1,39-3, if any								12
13	Other (specify):	See Pg 16A								13
14	TOTAL			\$		\$	\$		\$	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.

You may be better off inserting last year's PG 16A here and clearing out the data, vs. importing the Frx Pg 16 report...

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Center, Inc # 003-6244 Report Period Beginning: 1/1/2011 Ending: 12/31/2011
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>90,000</u>)	2,090,007	2,090,007	3
4	Supply Inventory (priced at)	255	255	4
5	Short-Term Investments			5
6	Prepaid Insurance		14,133	6
7	Other Prepaid Expenses	5,872	5,872	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	24,861	182,959	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,120,995	\$ 2,293,226	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,000,000	1,000,000	12
13	Land		155,893	13
14	Buildings, at Historical Cost		6,904,761	14
15	Leasehold Improvements, at Historical Cost	729,299	975,618	15
16	Equipment, at Historical Cost	598,986	2,128,318	16
17	Accumulated Depreciation (book methods)	(1,048,559)	(6,690,128)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Repl resrv, CIP, S/holder</u> <u>19,469</u>	19,469	388,465	22
23	Other(specify): <u>Due from affiliates</u>		719,677	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,299,195	\$ 5,582,603	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,420,190	\$ 7,875,829	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 654,112	\$ 610,698	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,961	54,961	28
29	Short-Term Notes Payable		80,182	29
30	Accrued Salaries Payable	363,939	363,939	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	70,354	70,354	31
32	Accrued Real Estate Taxes(Sch.IX-B)		269,800	32
33	Accrued Interest Payable	175,865	202,897	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr Exp,Due HFS,SalesTax,Etc.</u>	134,521	134,521	36
37	<u>Due to affiliates</u>	908,910	908,910	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,362,662	\$ 2,696,262	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,698,733	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to affiliates</u>	8,701,498	8,701,498	43
44	<u>S/holder loans, others</u>	250,000	250,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,951,498	\$ 16,650,231	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,314,160	\$ 19,346,493	46
47	TOTAL EQUITY (page 18, line 24)	\$ (7,893,970)	\$ (11,470,664)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,420,190	\$ 7,875,829	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,636,372)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,636,372)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(257,598)	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)	\$ (257,598)	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)	\$ (7,893,970)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Princeton Rehabilitation and Health Care Ce # 003-6244 Report Period Beginning: 1/1/2011

Ending: 12/31/2011

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,806,456	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,806,456	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	40,597	6
7	Oxygen	64,072	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 104,669	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	24	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,936	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,960	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38,862	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,862	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See page 19a</u>	18,747	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,747	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,971,694	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,620,128	31
32	Health Care	3,319,496	32
33	General Administration	2,555,348	33
	B. Capital Expense		
34	Ownership	1,032,263	34
	C. Ancillary Expense		
35	Special Cost Centers	578,869	35
36	Provider Participation Fee	123,188	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,229,292	40
41	Income before Income Taxes (line 30 minus line 40)**	(257,598)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (257,598)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done 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.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden Princeton Rehabilitation and Healt # 001-7319 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Micellaneous Income	\$ 1,690
Gain on Sale of Fixed Assets	17,057
Line 28 Total:	<u>18,747</u>

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	2,104	2,104	\$ 91,049	\$ 43.27	1
2	Assistant Director of Nursing	1,832	1,984	73,803	37.20	2
3	Registered Nurses	12,385	13,045	370,470	28.40	3
4	Licensed Practical Nurses	34,598	37,651	944,527	25.09	4
5	CNAs & Orderlies	84,542	91,695	892,769	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,945	2,128	27,172	12.77	8
9	Activity Director	2,080	2,080	35,218	16.93	9
10	Activity Assistants	6,495	6,901	62,303	9.03	10
11	Social Service Workers	1,968	2,041	39,497	19.35	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	53,237	25.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,158	23,331	245,988	10.54	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	41,110	19.76	17
18	Housekeepers	23,200	24,895	267,875	10.76	18
19	Laundry	5,495	6,005	50,127	8.35	19
20	Administrator	1,800	1,962	80,103	40.83	20
21	Assistant Administrator	2,056	2,113	60,765	28.76	21
22	Other Administrative	9,976	9,976	240,806	24.14	22
23	Office Manager	2,080	2,080	32,305	15.53	23
24	Clerical	2,416	2,510	20,666	8.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,400	4,401	130,574	29.67	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,218	1,270	17,172	13.52	31
32	Other Health Care Behavior	9,084	9,488	154,156	16.25	32
33	Other(specify) Behavior	7,625	8,115	78,211	9.64	33
34	TOTAL (lines 1 - 33)	242,617	259,935	\$ 4,009,903 *	\$ 15.43	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	1900/monthly	\$ 22,800	1-3	35
36	Medical Director	2750/monthly	33,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	396/monthly	4,752	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	299/monthly	3,588	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 64,140		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

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	
			0	\$	Workers' Compensation Insurance		\$	IDPH License Fee		\$	
			0		Unemployment Compensation Insurance			Advertising: Employee Recruitment			
			0		FICA Taxes			Health Care Worker Background Check			
			0		Employee Health Insurance			(Indicate # of checks performed 0)			
			0		Employee Meals			Patient Background Checks		0	
			0		Illinois Municipal Retirement Fund (IMRF)*						
			0								
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$							
B. Administrative - Other								Related parties			
Description				Amount				Less: Public Relations Expense		()	
				\$				Non-allowable advertising		()	
								Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$	TOTAL (agree to Sch. V, line 20, col. 8)		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount
Alden Management Services, Inc.		Consulting		\$				\$	Out-of-State Travel		\$
									In-State Travel		
									Related parties		
									Seminar Expense		
									Entertainment Expense		()
									(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$	TOTAL		\$	TOTAL		\$	

* Attach copy of IMRF notifications

**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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

no

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

Line10

(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?

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

x

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$123,188

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 benefit on Schedule V.

\$0

Has any meal income been offset against related costs?Indicate the amount. \$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

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:

(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?

Attach invoices and a summary of services for all architect and appraisal fees
- HFS 3745 (N-4-99)
- IL478-2471