

		FOR BHF USE					

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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: 0040899 Facility Name: Arlington Rehab & Living Center Address: 1666 Rfd (Checker Road) Long Grove 60047 County: Lake Telephone Number: (847) 419-1111 Fax # (847) 419-1119 HFS ID Number: Date of Initial License for Current Owners: 12/26/1995 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other
--

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed)

(Print Name and Title) Andrew B. Cutler

(Firm Name & Address) FGMK, LLC 2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015

(Telephone) (847) 374-0400 Fax # (847) 374-0420

In the event there are further questions about this report, please contact:

Name: Andrew Cutler Telephone Number: (847) 940-3269

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 01/01/2011 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.

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 Arlington Rehab & Living Center

0040899 Report Period Beginning: 01/01/2011 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>190</u>	Skilled (SNF)	<u>190</u>	<u>69,350</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>190</u>	TOTALS	<u>190</u>	<u>69,350</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>42,259</u>	<u>4,999</u>	<u>13,674</u>	<u>60,932</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,259</u>	<u>4,999</u>	<u>13,674</u>	<u>60,932</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.86%

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 01/02/1996

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/02/1996 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 190 and days of care provided 12,765

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS
ACCUAL ☒ 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		Arlington Rehab & Living Center				#	0040899	Report Period Beginning:		01/01/2011		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	535,960	125,672	29,347	690,979		690,979		690,979						1
2	Food Purchase		423,961		423,961	(4,105)	419,856	(348)	419,508						2
3	Housekeeping	250,469	50,031		300,500		300,500		300,500						3
4	Laundry	63,960	92,852		156,812		156,812		156,812						4
5	Heat and Other Utilities			229,369	229,369		229,369	(17,667)	211,702						5
6	Maintenance	73,635	42,524	85,238	201,397		201,397	(11,078)	190,319						6
7	Other (specify):*														7
8	TOTAL General Services	924,024	735,040	343,954	2,003,018	(4,105)	1,998,913	(29,093)	1,969,820						8
	B. Health Care and Programs														
9	Medical Director			54,300	54,300		54,300	(6,952)	47,348						9
10	Nursing and Medical Records	3,923,073	233,329	15,197	4,171,599		4,171,599	79,459	4,251,058						10
10a	Therapy	177,100			177,100		177,100		177,100						10a
11	Activities	224,269	5,112	3,416	232,797		232,797		232,797						11
12	Social Services	150,073	2,915	1,414	154,402		154,402		154,402						12
13	CNA Training														13
14	Program Transportation														14
15	Other (specify):*							15,319	15,319						15
16	TOTAL Health Care and Programs	4,474,515	241,356	74,327	4,790,198		4,790,198	87,826	4,878,024						16
	C. General Administration														
17	Administrative	130,740		730,669	861,409		861,409	(435,363)	426,046						17
18	Directors Fees														18
19	Professional Services			99,822	99,822		99,822	(30,682)	69,140						19
20	Dues, Fees, Subscriptions & Promotions			56,093	56,093		56,093	(18,566)	37,527						20
21	Clerical & General Office Expenses	214,596	26,608	501,879	743,083		743,083	(375,111)	367,972						21
22	Employee Benefits & Payroll Taxes			781,124	781,124	4,105	785,229		785,229						22
23	Inservice Training & Education														23
24	Travel and Seminar			9,851	9,851		9,851	1,763	11,614						24
25	Other Admin. Staff Transportation			10,761	10,761		10,761	30,986	41,747						25
26	Insurance-Prop.Liab.Malpractice			479,452	479,452		479,452	306	479,758						26
27	Other (specify):*							44,889	44,889						27
28	TOTAL General Administration	345,336	26,608	2,669,651	3,041,595	4,105	3,045,700	(781,778)	2,263,922						28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,743,875	1,003,004	3,087,932	9,834,811		9,834,811	(723,044)	9,111,767						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.

Arlington Rehab & Living Center
0040899
Cost Report Reclassifications
01/01/2011
12/31/2011

Schedule V
Line #

22	Employee Benefits	4,105	
2	Food		4,105

To reclass cost of employee meals from raw food to employee benefits

33	Real Estate Tax		
19	Professional Fees		

To reclass cost of appealing real estate taxes

Arlington Rehab & Living Center
0040899
Schedule of Other Admin. Staff Transportation
01/01/2011
12/31/2011

Auto Expense: Arlington Rehab & Living Center	\$ 10,761
Auto Expense: Related Parties - See Page 6's	30,986.00
Auto Expense: Page 5 and 5a Adjustments	-
Auto Expense: Total	<u>\$ 41,747</u>

The Arlington Rehabilitation and Living Center
0040899
Other Admin. Staff Transportation
01/01/11-12/31/11

Date	G/L Acct #	Employee Name	Reference	Amount
1/7/2011	90-6062-00	URSZULA SZCZEPURA	MILEAGE	84.00
1/26/2011	90-6062-00	AMANDA COWIE	MILEAGE	10.80
1/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	187.60
1/31/2011	90-6062-00	BRIGET SIMBILA	MILEAGE	79.56
1/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	187.60
1/31/2011	90-6062-00	TORRIE MCALEVY	MILEAGE	51.78
1/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	(187.60)
1/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	42.16
1/31/2011	90-6062-00	DANIELLE STASI	MILEAGE	2.80
2/4/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	40.00
2/11/2011	90-6062-00	GISELL DA SILVA	MILEAGE	8.75
2/17/2011	90-6062-00	GISELL DA SILVA	MILEAGE	5.18
2/28/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	143.65
3/8/2011	90-6062-00	GISELL DA SILVA	MILEAGE	5.20
3/23/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	191.52
3/31/2011	90-6062-00	GISELL DA SILVA	MILEAGE	3.00
4/12/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	37.05
4/30/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	253.43
4/30/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	(253.43)
4/30/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	253.43
4/30/2011	90-6062-00	URSZULA SZCZEPURA	01/01-04/30/11 BANKING MILES	220.80
4/30/2011	90-6062-00	GISELL DA SILVA	MILEAGE	1.50
5/9/2011	90-6062-00	GISELL DA SILVA	MILEAGE	6.31
5/24/2011	90-6062-00	EXXON MOBIL	FUEL FOR TRUCK AND/OR VAN	100.21
5/31/2011	90-6062-00	GISELL DA SILVA	REIMBURSED GAS, TOLLS/PARKING	257.63
5/31/2011	90-6062-00	GISELL DA SILVA	MILEAGE	3.00
6/9/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	283.05
6/9/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	(283.05)
6/20/2011	90-6062-00	JACKIE MINOGUE	MILEAGE	403.55
6/30/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	188.34
6/30/2011	90-6062-00	JACKIE MINOGUE	MILEAGE	213.13
7/1/2011	90-6062-00	JACKIE MINOGUE	MILEAGE	268.29
7/1/2011	90-6062-00	GISELL DA SILVA	MILEAGE	1.02
7/1/2011	90-6062-00	URSZULA SZCZEPURA	MILEAGE	69.00
7/19/2011	90-6062-00	GISELL DA SILVA	MILEAGE	1.10
7/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	489.35
7/31/2011	90-6062-00	GISELL DA SILVA	MILEAGE	3.70
7/31/2011	90-6062-00	JACKIE MINOGUE	7/18-7/29 MILEAGE	289.51
8/1/2011	90-6062-00	EXXON MOBIL	FUEL FOR TRUCK AND/OR VAN	278.63
8/1/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	291.95
8/1/2011	90-6062-00	LUIS BRIONES	EXPENSE REPORT 4/18-8/04/2011	103.27
8/1/2011	90-6062-00	JOSE ESTRADA	Purchases	33.62
8/15/2011	90-6062-00	JACKIE MINOGUE	AUGUST AUTO EXPENSE 8/15-8/26	290.17
8/18/2011	90-6062-00	ALFREDO GONZALEZ	LAUNDRY SERVICES AUTO EXPENSE	74.37
8/31/2011	90-6062-00	URSZULA SZCZEPURA	BANKING MILES 05/1-08/31/11	247.94
8/31/2011	90-6062-00	DAVID ZARUBA	PARKING/TOLLS	12.00
8/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	356.00
9/1/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	295.72
9/1/2011	90-6062-00	GISELL DA SILVA	MILEAGE	11.87
9/7/2011	90-6062-00	KAROLINA WROBLEWSKA	TO THE POST OFFICE	2.45
9/23/2011	90-6062-00	EXXON MOBIL	FUEL FOR TRUCK AND/OR VAN	25.04
9/23/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	281.40
9/30/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	440.49
9/30/2011	90-6062-00	GISELL DA SILVA	MILEAGE	16.38
10/1/2011	90-6062-00	JACKIE MINOGUE	09/26-10/07/11 EXPENSE REPORT	218.24
10/1/2011	90-6062-00	EXXON MOBIL	FUEL FOR TRUCK AND/OR VAN	103.65
10/19/2011	90-6062-00	APEX HEALTHCARE	TRUCK BREAKDOWN REPAIRS-HOPKIN	169.19
10/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REC L SILBERSCHIEN DEBIT TRANS	277.95
10/31/2011	90-6062-00	GISELL DA SILVA	MILEAGE	5.99
11/1/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	243.12
11/17/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	279.86
11/23/2011	90-6062-00	KATHY KOZISEK	MILEAGE 10/20-11/16	840.60
11/30/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	403.30
11/30/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	235.78
12/1/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	254.42
12/1/2011	90-6062-00	JOSE ESTRADA	MILEAGE 9/16-12/1/2011	34.41
12/7/2011	90-6062-00	EXXON MOBIL	AUTO EXPENSE-GAS 12/07/11	163.26
12/9/2011	90-6062-00	KATHY KOZISEK	MILEAGE	607.10
12/31/2011	90-6062-00	LINDSEY SIBERSCHEIN	REIMBURSED GAS, TOLLS/PARKING	231.28
12/31/2011	90-6062-00	APEX HEALTHCARE	AUTO EXPENSE-B. HOPKINS	42.30
12/31/2011	90-6062-00	JACKIE MINOGUE	MILEAGE/TOLLS	226.33
Related Party APEX Allocation				30,986.00
Total				<u><u>41,747.00</u></u>

Facility Name & ID Number Arlington Rehab & Living Center #0040899 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			176,880	176,880		176,880	265,977	442,857			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			166,897	166,897		166,897	(166,897)				32
33	Real Estate Taxes			75,581	75,581		75,581		75,581			33
34	Rent-Facility & Grounds			1,159,313	1,159,313		1,159,313	(1,155,571)	3,742			34
35	Rent-Equipment & Vehicles			10,579	10,579		10,579	4,329	14,908			35
36	Other (specify):*											36
37	TOTAL Ownership			1,589,250	1,589,250		1,589,250	(1,052,162)	537,088			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		560,560	1,684,799	2,245,359		2,245,359	(146,872)	2,098,487			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	26,984		29,175	56,159		56,159	(30,693)	25,466			41
42	Provider Participation Fee			281,409	281,409		281,409		281,409			42
43	Other (specify):*	143,275		236,110	379,385		379,385	(379,385)				43
44	TOTAL Special Cost Centers	170,259	560,560	2,231,493	2,962,312		2,962,312	(556,950)	2,405,362			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,914,134	1,563,564	6,908,675	14,386,373		14,386,373	(2,332,156)	12,054,217			45

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

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	(17,667)	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	149,931	30		9
10	Interest and Other Investment Income	(11,840)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(348)	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	(10,072)	21		18
19	Entertainment	(4,254)	21		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	(352,250)	21		24
25	Fund Raising, Advertising and Promotional	(25,916)	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	(811,205)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,083,620)		\$	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)	(1,248,536)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,248,536)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,332,156)		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.			\$		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

Report Period Beginning:

Ending:

ID# 0040899

01/01/2011

12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Patient Needs	\$ (2,915)	10	1
2	Bistro Income	(30,693)	41	2
3	Public Relations	(1,265)	20	3
4	Bank Charges	(7,973)	21	4
5	Credit Card Processing Fees	(2,325)	21	5
6	Medical Records Income	(886)	10	6
7	Jury Duty Income	(39)	10	7
8	Rental Income	(8,000)	21	8
9	Marketing Salaries	(143,275)	43	9
10	Bank Charges - Building Co.	(688)	21	10
11	Management Fees - Building Co.	(46,373)	19	11
12	State Income Tax - Building Co.	(10,478)	21	12
13	Trust Fees - Building Co.	(440)	21	13
14	Franchise Tax	(2,851)	21	14
15	Non-Allowable Interest Expense	(303,761)	32	15
16	Non-Allowable Legal	(236,110)	43	16
17	Medicare Payment Adjustment	(11)	10	17
18	Non-Allowable Seminar	(869)	24	18
19	Capitalized R&M	(12,253)	06	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	(811,205)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

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													
Depreciation	149,931	116,046										265,977	30
Amortization of Pre-Op. & Org.													31
Interest	(315,601)	147,421		1,283								(166,897)	32
Real Estate Taxes													33
Rent-Facility & Grounds		(1,159,313)		3,742								(1,155,571)	34
Rent-Equipment & Vehicles				4,329								4,329	35
Other (specify):*													36
TOTAL Ownership	(165,670)	(895,846)		9,354								(1,052,162)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation													38
Ancillary Service Centers			(146,872)									(146,872)	39
Barber and Beauty Shops													40
Coffee and Gift Shops	(30,693)											(30,693)	41
Provider Participation Fee													42
Other (specify):*	(379,385)											(379,385)	43
TOTAL Special Cost Centers	(410,078)		(146,872)									(556,950)	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,083,620)	(895,846)	(146,872)	(205,818)								(2,332,156)	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
See Supplemental for related party information						

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 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Rent	\$ 1,159,313	Kedzie Home LLC	100.00%	\$	(1,159,313)	1
2	V	30	Depreciation		Kedzie Home LLC	100.00%	116,046	116,046	2
3	V	32	Interest Expense		Kedzie Home LLC	100.00%	147,421	147,421	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,159,313			\$ 263,467	\$ * (895,846)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary Rehab	\$ 1,650,064	Simply Rehab		\$ 1,503,192	\$ (146,872)	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			\$ 1,650,064			\$ 1,503,192	\$ * (146,872)	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	6	BUILDING SUPPLIES	\$	APEX HEALTHCARE SOLUTIONS LLC	100.00%	\$ 1,035	\$ 1,035	15
16	V	10	NURSING SALARIES		APEX HEALTHCARE SOLUTIONS LLC	100.00%	55,624	55,624	16
17	V	15	EMP. BEN. - NURSING		APEX HEALTHCARE SOLUTIONS LLC	100.00%	15,319	15,319	17
18	V	17	ADMINISTRATIVE SALARIES - NON OWNER		APEX HEALTHCARE SOLUTIONS LLC	100.00%	295,306	295,306	18
19	V	19	PROFESSIONAL FEES		APEX HEALTHCARE SOLUTIONS LLC	100.00%	15,691	15,691	19
20	V	20	FEES, SUBSCRIPTIONS		APEX HEALTHCARE SOLUTIONS LLC	100.00%	8,615	8,615	20
21	V	21	CLERICAL & GENERAL		APEX HEALTHCARE SOLUTIONS LLC	100.00%	20,333	20,333	21
22	V	24	SEMINARS		APEX HEALTHCARE SOLUTIONS LLC	100.00%	2,632	2,632	22
23	V	25	AUTO & TRAVEL		APEX HEALTHCARE SOLUTIONS LLC	100.00%	20,621	20,621	23
24	V	26	INSURANCE		APEX HEALTHCARE SOLUTIONS LLC	100.00%	306	306	24
25	V	27	EMP. BEN. - GEN. ADMIN.		APEX HEALTHCARE SOLUTIONS LLC	100.00%	44,889	44,889	25
26	V	32	INTEREST		APEX HEALTHCARE SOLUTIONS LLC	100.00%	1,283	1,283	26
27	V	34	RENT		APEX HEALTHCARE SOLUTIONS LLC	100.00%	3,742	3,742	27
28	V	35	AUTO RENTAL		APEX HEALTHCARE SOLUTIONS LLC	100.00%	1,793	1,793	28
29	V	35	EQUIPMENT RENTAL		APEX HEALTHCARE SOLUTIONS LLC	100.00%	2,536	2,536	29
30	V	25	ILLINOIS ONLY - TRAVEL		APEX HEALTHCARE SOLUTIONS LLC	100.00%	10,365	10,365	30
31	V	6	MAINTENANCE/FACILITIES CONSULTANT		APEX HEALTHCARE SOLUTIONS LLC	100.00%	140	140	31
32	V	9	MEDICAL DIRECTOR - REIMBURSED		APEX HEALTHCARE SOLUTIONS LLC	100.00%	(6,952)	(6,952)	32
33	V	10	RISK MANAGEMENT SALARIES		APEX HEALTHCARE SOLUTIONS LLC	100.00%	27,686	27,686	33
34	V	21	OFFICE SALARIES		APEX HEALTHCARE SOLUTIONS LLC	100.00%	3,887	3,887	34
35	V								35
36	V	17	MANAGEMENT FEES	730,669	APEX HEALTHCARE SOLUTIONS LLC	100.00%		(730,669)	36
37	V								37
38	V								38
39	Total			\$ 730,669			\$ 524,851	\$ * (205,818)	39

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

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	Arado, Whitney	2.00%	Aurora Rehabilitation Center	Aurora, IL	Kedzie Home	Chicago, IL	Building Co.	1
2	Dougherty, Gayle	16.80%	Kolob - Cedar City	Cedar City, UT	APEX Healthcare Solu	Long Grove, IL	Management	2
3	Lawton, Shelley Loyd	16.80%	Kolob - St. George	St. George, UT	Simply Rehab.	Skokie, IL	Therapy	3
4	Lefkovitz, Glenn	16.80%	Carver Living Center	Durham, NC	Aurora Supportive Liv	Aurora, IL	SLF	4
5	Mann, James	10.00%	Willow Ridge	Rutherfordton, NC	Coles Supportive Livin	Chicago, IL	SLF	5
6	Mann, Nina	16.80%	Pineville Rehabilitation & Living Center	Pineville, NC	Jackson Park Supporti	Chicago, IL	SLF	6
7	Thomas & Donna Neshek Revocable Trust	16.80%	Ridgewood RLC, LLC	Washington, NC	Robbins Supportive Li	Robbins, IL	SLF	7
8	Papas, Patricia	1.00%	Broomfield Skilled Nursing	Broomfield, CO	Rockford Supportive L	Rockford, IL	SLF	8
9	Rosenberg, Sheldon	3.00%						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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aaron Mann	Director of Operation	Administrative		See Attached	16	40.00	Alloc. Salary	\$ 120,000	17-03	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 120,000		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 Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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

Facility Name & ID Number Arlington Rehab & Living Center # 0040899 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Simply Rehab
Street Address 801 Skokie Blvd., Suite 108
City / State / Zip Code Northbrook, IL 60062
Phone Number (847) 562-0800
Fax Number (847) 562-0070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Rehab	Direct Allocation	190		\$ 1,503,192	\$	190	\$ 1,503,192	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,503,192	\$		\$ 1,503,192	25

Facility Name & ID Number Arlington Rehab & Living Center# 0040899 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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

1425 MC HENRY ROAD, SUITE 209

City / State / Zip Code

BUFFALO GROVE, IL, 60089

Phone Number

(224) 377-2400

Fax Number

(224) 377-2491

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	BUILDING SUPPLIES	MGMT FEES/PAT DAYS		9	\$ 7,442	\$	60,932	\$ 1,035	1
2	10	NURSING SALARIES	DIRECT/PAT DAYS		14	463,968		60,932	55,624	2
3	15	EMP. BEN. - NURSING	MGMT FEES/PAT DAYS		14	110,211		60,932	15,319	3
4	17	ADMINISTRATIVE SALARIES -	DIRECT/PAT DAYS		14	1,727,853		60,932	295,306	4
5	19	PROFESSIONAL FEES	MGMT FEES/PAT DAYS		14	112,883		60,932	15,691	5
6	20	FEES, SUBSCRIPTIONS	MGMT FEES/PAT DAYS		14	61,987		60,932	8,615	6
7	21	CLERICAL & GENERAL	MGMT FEES/PAT DAYS		14	146,277		60,932	20,333	7
8	24	SEMINARS	MGMT FEES/PAT DAYS		14	18,933		60,932	2,632	8
9	25	AUTO & TRAVEL	MGMT FEES/PAT DAYS		14	148,354		60,932	20,621	9
10	26	INSURANCE	MGMT FEES/PAT DAYS		14	2,203		60,932	306	10
11	27	EMP. BEN. - GEN. ADMIN.	MGMT FEES/PAT DAYS		14	312,614		60,932	44,889	11
12	32	INTEREST	MGMT FEES/PAT DAYS		14	9,236		60,932	1,283	12
13	34	RENT	MGMT FEES/PAT DAYS		14	26,933		60,932	3,742	13
14	35	AUTO RENTAL	MGMT FEES/PAT DAYS		14	12,897		60,932	1,793	14
15	35	EQUIPMENT RENTAL	MGMT FEES/PAT DAYS		14	18,257		60,932	2,536	15
16	25	ILLINOIS ONLY - TRAVEL	DIRECT/PAT DAYS		2	17,757		60,932	10,365	16
17	6	MAINTENANCE/FACILITIES C	MGMT FEES/PAT DAYS		9	1,017		60,932	140	17
18	9	MEDICAL DIRECTOR - REIMB	MGMT FEES/PAT DAYS		9	(50,000)		60,932	(6,952)	18
19	10	RISK MANAGEMENT SALARIE	MGMT FEES/PAT DAYS		14	199,181		60,932	27,686	19
20	21	OFFICE SALARIES	MGMT FEES/PAT DAYS		14	27,964		60,932	3,887	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,375,967	\$		\$ 524,851	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	Shareholder Loans	X		Working Capital				2,664,985			106,565	6
7	First Bank		X	Line of Credit							500	7
8	Venture Fund	X		Working Capital				1,148,654			59,832	8
9	TOTAL Facility Related						\$	3,813,639			\$ 166,897	9
	B. Non-Facility Related*											
10	Interest Income		X								(11,840)	10
11	Alloc. From APEX HC Solut.		X								1,283	11
12	Venture Fund (Bldg. Co.)	X						2,484,129			147,421	12
13	Adjusted on page 5										(303,761)	13
14	TOTAL Non-Facility Related						\$	2,484,129			\$ (166,897)	14
15	TOTALS (line 9+line14)						\$	6,297,768			\$	15

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

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

** 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 2010 report.				\$	129,296	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.)				\$	99,940	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(29,356)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	104,937	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.)				\$		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.				\$	75,581	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	107,415	8	FOR BHF USE ONLY	
		2007	106,719	9		
		2008	119,309	10	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
		2009	123,139	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2010	99,940	12	15	LESS REFUND FROM LINE 6 \$ 15
2011 Accrual= \$99,940 x 1.05				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arlington Rehab & Living Center COUNTY Lake
FACILITY IDPH LICENSE NUMBER 0040899
CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler
TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

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)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>15-31-201-082</u>	<u>Long Term Care Property</u>	\$ <u>93,783.28</u>	\$ <u>93,783.28</u>
2.	<u>15-31-201-083</u>	<u>Long Term Care Property</u>	\$ <u>6,156.48</u>	\$ <u>6,156.48</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>99,939.76</u>	\$ <u>99,939.76</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 provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,302

B. General Construction Type: Exterior Cinder BlockFrame Drivit/Face BrickNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility☒ (b) Rent from a Related Organization.☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment☐ (b) Rent equipment from a Related Organization.☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

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

[illegible]

***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

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		\$	\$		\$	\$	\$	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	Related Building Company (Pages 12F & 12G)	6,022,246	116,046		177,367	61,321	1,852,569	67
68	Related Party Allocations (Pages 12H & 12I)							68
69	Financial Statement Depreciation		176,880			(176,880)		69
70	TOTAL (lines 4 thru 69)	\$ 7,477,056	\$ 292,926		\$ 265,525	\$ (27,401)	\$ 2,448,548	70

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/2011

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		\$ 7,477,056	\$ 292,926		\$ 265,525	\$ (27,401)	\$ 2,448,548	1
2 <u>New Unit Drapery</u>	2008	8,156		20	408	408	1,631	2
3 <u>Wallcoverings - New Unit</u>	2008	6,763		20	338	338	1,324	3
4 <u>New Phone System</u>	2008	21,103		20	1,055	1,055	3,781	4
5 <u>Plumbing</u>	2008	9,274		20	464	464	1,623	5
6 <u>Resurface Parking Lot</u>	2008	43,650		20	2,183	2,183	7,276	6
7 <u>Flooring</u>	2008	5,343		20	267	267	890	7
8 <u>Flooring</u>	2008	27,646		20	1,382	1,382	5,299	8
9 <u>Flooring</u>	2008	27,646		20	1,382	1,382	5,299	9
10 <u>Flooring</u>	2008	27,646		20	1,382	1,382	5,183	10
11 <u>Flooring</u>	2008	17,898		20	895	895	3,356	11
12 <u>Flooring</u>	2008	16,129		20	806	806	2,957	12
13 <u>Flooring</u>	2008	5,376		20	269	269	941	13
14 <u>Carpet</u>	2008	2,797		20	140	140	525	14
15 <u>Carpet</u>	2008	4,813		20	241	241	883	15
16 <u>Carpet</u>	2008	3,534		20	177	177	678	16
17 <u>Carpet</u>	2008	2,799		20	140	140	537	17
18 <u>Service Outside Lights</u>	2008	5,997		20	300	300	1,000	18
19 <u>Flooring & Installation</u>	2008	50,000		20	2,500	2,500	9,583	19
20 <u>Repair Fixture Sockets</u>	2008	2,611		20	131	131	425	20
21 <u>Remodeling - Transfer Fan</u>	2008	4,080		20	204	204	646	21
22 <u>Repair Basement, Dish Room, Kitchen, Door, Security Devices</u>	2008	4,208		20	210	210	718	22
23 <u>Electrical Work</u>	2008	7,412		20	371	371	1,298	23
24 <u>Flooring, Laundry & Dining Room Repairs</u>	2008	10,103		20	505	505	1,599	24
25 <u>Painting, Stain, Door & Frames</u>	2008	13,174		20	659	659	2,470	25
26 <u>Flooring</u>	2008	15,674		20	784	784	2,874	26
27 <u>Floor Repair & Clinical Service Sink</u>	2008	18,515		20	926	926	3,472	27
28 <u>Flooring & Carpet</u>	2008	19,036		20	952	952	3,490	28
29 <u>Demolition, Drywall, Paint</u>	2008	28,704		20	1,435	1,435	5,262	29
30 <u>Repair Eifs</u>	2008	9,600		20	480	480	1,720	30
31 <u>Underground Well System Repair</u>	2008	2,800		20	140	140	502	31
32 <u>Bathroom Flooring</u>	2008	6,476		20	324	324	1,106	32
33 <u>Floor Installation</u>	2008	7,484		20	374	374	1,310	33
34 TOTAL (lines 1 thru 33)		\$ 7,913,503	\$ 292,926		\$ 287,347	\$ (5,579)	\$ 2,528,205	34

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/2011

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,913,503	\$ 292,926		\$ 287,347	\$ (5,579)	\$ 2,528,205	1
2	Ceiling Tile, Shelving, Painting	2008	10,915		20	546	546	2,092	2
3	Flooring & Carpet	2008	3,516		20	176	176	674	3
4	Bedroom Floor & Wall Base	2008	17,071		20	854	854	3,272	4
5	Therapy Room Flooring	2008	7,904		20	395	395	1,515	5
6	Bedroom Flooring	2008	20,359		20	1,018	1,018	3,902	6
7	Bedroom Flooring	2008	21,644		20	1,082	1,082	4,058	7
8	Lobby & Dining Room Flooring	2008	9,255		20	463	463	1,736	8
9	Flooring	2008	3,303		20	165	165	537	9
10	Flooring	2008	11,895		20	595	595	2,131	10
11	Plumbing - Dishwashing Room	2008	3,314		20	166	166	566	11
12	Bathroom Flooring	2008	3,670		20	184	184	628	12
13	Flooring	2008	6,166		20	308	308	1,156	13
14	Flooring	2008	17,855		20	893	893	3,348	14
15	Toilets	2008	25,768		20	1,288	1,288	4,402	15
16	Carpet	2008	2,817		20	141	141	517	16
17	Doors & Frames, Hager Strip, Power Supply, Keypads, Hinges	2008	30,425		20	1,521	1,521	6,085	17
18	Insulate Fore Access Panel, Door	2008	2,823		20	141	141	564	18
19	Data & Cable Wiring, Termination, Testing	2008	4,560		20	228	228	912	19
20	Ceiling Grid, Painting Walls, Ceilings, Doors	2008	35,355		20	1,768	1,768	7,068	20
21	Excavation & Concrete, Grading Walls, Strip Dirt, Trench For Foo	2008	184,788		20	9,239	9,239	36,957	21
22	Tile Base And Bath Floor Tiles	2008	11,037		20	552	552	2,208	22
23	Flooring, Ceramic Tiles, Carpeting	2008	10,884		20	544	544	2,131	23
24	Carpeting	2008	5,477		20	274	274	1,073	24
25	Sprinklers - Piping, Valves, Trim, Repairs For Tie-Ins, Certification	2008	50,933		20	2,547	2,547	9,975	25
26	Piping System Installation	2008	168,690		20	8,435	8,435	33,036	26
27	Doors, Showers, Bathroom, Curtains	2008	42,165		20	2,108	2,108	8,257	27
28	Hallway And Dining Room Wallpaper	2008	5,275		20	264	264	1,033	28
29	Radiant Heating	2008	110,295		20	5,515	5,515	21,600	29
30	Electrical Work, Lighting, Alarm	2008	288,122		20	14,406	14,406	57,624	30
31	Remodeling - Carpet Fire Treatment	2008	5,177		20	259	259	798	31
32	Base Boards	2009	13,807		20	690	690	1,783	32
33	Railings	2009	17,901		20	895	895	2,312	33
34	TOTAL (lines 1 thru 33)		\$ 9,066,669	\$ 292,926		\$ 345,006	\$ 52,080	\$ 2,752,153	34

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

Facility Name & ID Number Arlington Rehab & Living Center

0040899

Report Period Beginning:

01/01/2011

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,066,669	\$ 292,926		\$ 345,006	\$ 52,080	\$ 2,752,153	1
2	Base Boards	2009	7,789		20	389	389	1,006	2
3	Wallcovering	2009	23,908		20	1,195	1,195	3,486	3
4	Flooring	2009	6,720		20	336	336	980	4
5	Countertops	2009	13,613		20	681	681	1,986	5
6	Nurses Station Remodel	2009	2,999		20	150	150	425	6
7	Brickwork	2009	2,528		20	126	126	347	7
8	Relocated Bathroom	2009	5,725		20	286	286	811	8
9	Lobby Remodel - Architect Services	2009	6,449		20	322	322	940	9
10	Remodel Work - Walls & Flooring	2009	21,552		20	1,078	1,078	3,054	10
11	Remodel Work - Painting & Plaster Work	2009	6,620		20	331	331	965	11
12	Therapy Remodel - Demoish Office, Rebuilt Framing	2009	5,040		20	252	252	735	12
13	Electrical Work	2009	3,433		20	172	172	501	13
14	Coordination Of Remodeling, Water System Corrections	2009	10,174		20	509	509	1,484	14
15	Flooring & Walls	2009	7,700		20	385	385	1,155	15
16	Remodel Work - Relocate Piping	2009	6,560		20	328	328	902	16
17	Remodel Bistro - Insulation	2009	8,925		20	446	446	1,153	17
18	Remodeling - Floors, Wall Cover, Handrails	2009	11,650		20	583	583	1,602	18
19	Remodeling - Walls & Floors	2009	12,526		20	626	626	1,722	19
20	Remodel Work In Bathroom, Kitchen And Salon	2009	22,773		20	1,139	1,139	3,037	20
21	Remodeling - Floors & Handrails	2009	23,874		20	1,194	1,194	3,084	21
22	Remodeling - Walls	2009	10,033		20	502	502	1,171	22
23	Bathroom Remode - Wall/Floor Tiles, Paint, Light Fixtures	2009	18,385		20	919	919	1,991	23
24	Bathroom Remode - Wall/Floor Tiles Paint	2009	30,950		20	1,548	1,548	3,353	24
25	Remodeling - Floors	2009	3,650		20	183	183	396	25
26	Therapy Room Remode - Floors, Walls, Ceiling	2009	6,288		20	314	314	864	26
27	Walls, Flooring, Painting	2009	11,580		20	579	579	1,544	27
28	Bistro - Granite Countertops & Backsplash	2009	3,595		20	180	180	480	28
29	Electrical Work For Remodeling	2009	23,923		20	1,196	1,196	3,389	29
30	Electrical Work For Remodeling	2009	12,478		20	624	624	1,560	30
31	Remodeling - Floors, Painting, Plumbing	2009	34,209		20	1,710	1,710	4,703	31
32	Remodeling - Floors, Painting, Plumbing	2009	34,723		20	1,736	1,736	4,485	32
33	Sprinkler Work	2009	8,460		20	423	423	1,128	33
34	TOTAL (lines 1 thru 33)		\$ 9,475,501	\$ 292,926		\$ 365,447	\$ 72,521	\$ 2,806,592	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 9,475,501	\$ 292,926		\$ 365,447	\$ 72,521	\$ 2,806,592	1
2	Architect Fees - Remodeling	2009	7,435		20	372	372	868	2
3	Wall Construction	2010	6,292		20	315	315	630	3
4	Sink & Drain	2010	6,815		20	341	341	682	4
5	Boiler Heat Exchange	2010	3,608		20	361	361	602	5
6	Boiler	2010	3,269		20	163	163	313	6
7	Fire Dampers	2010	4,943		20	247	247	453	7
8	Deep Well Pump	2010	8,945		20	447	447	782	8
9	Pull Pipe & Motor	2010	29,117		20	2,912	2,912	4,610	9
10	Site Survey	2010	4,993		20	250	250	333	10
11	Survey Repairs, Fans	2010	5,251		20	263	263	329	11
12	Water Plant Wall	2010	7,719		20	386	386	450	12
13	Hinges, Cooler Ducting	2010	9,689		20	484	484	524	13
14	Well Pump/Piping	2011	2,569		20	64	64	64	14
15	Well Pump Motor	2011	3,984		20	83	83	81	15
16	Elevator Repairs	2011	2,850		20	24	24	24	16
17	Elevator Repairs	2011	2,850		20	24	24	24	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,585,830	\$ 292,926		\$ 372,182	\$ 79,256	\$ 2,817,359	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 Building Company Information		\$	\$		\$	\$	\$	1
2 Buildings:								2
3	1996	20,105		35	1,005	1,005	16,082	3
4	1995	5,614,638		35	160,418	160,418	1,764,599	4
5 East Addition	2008	160,181		35	4,577	4,577	49,154	5
6 Building Company Book Depreciation			116,046			(116,046)		6
7								7
8 Leasehold Improvements:								8
9 Building Supplies	2008	4,371		20	219	219	438	9
10 Remodel Bathing Area in Room 344	2008	13,770		20	689	689	1,378	10
11 Architectural Services	2008	9,874		20	494	494	988	11
12 Remodel Shower Rooms 517 and 519	2008	4,407		20	220	220	440	12
13 Construction - Home Depot	2008	4,690		20	235	235	470	13
14 Electric Work	2008	37,907		20	1,895	1,895	3,790	14
15 Furnish & Install one stair Assembly with Header	2008	4,400		20	220	220	440	15
16 Framing, Drywall Hanging and Painting New Partitions	2008	103,064		20	5,153	5,153	10,306	16
17 Concrete Floor Opening	2008	4,600		20	230	230	460	17
18 East Addition and Wing 300 Remodeling	2008	25,853		20	1,293	1,293	2,586	18
19 Exhaust System	2008	14,386		20	719	719	1,438	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)		\$ 6,022,246	\$ 116,046		\$ 177,367	\$ 61,321	\$ 1,852,569	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	\$634,160	\$	\$63,679	\$63,679	10	\$325,803	71
72	Current Year Purchases	32,434		1,816	1,816	10	1,816	72
73	Fully Depreciated Assets	614,138				10	614,138	73
74								74
75	TOTALS	\$1,280,732	\$	\$65,495	\$65,495		\$941,757	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		FORD BUS-91	1996	\$24,698	\$	\$		5	\$24,698	76
77		BUS	1999	66,022				5	66,022	77
78		FORD F150 TRUCK	2008	25,900		5,180	5,180	5	16,403	78
79										79
80	TOTALS			\$116,620	\$	\$5,180	\$5,180		\$107,123	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,155,374	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$292,926	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$442,857	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$149,931	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,866,239	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	Fire Alarm System/Panel	\$32,658	92
93			93
94			94
95		\$32,658	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YESNO
- If NO, see instructions.

		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	Allocated from APEX HC Solutions				3,742			5
6								6
7	TOTAL				\$3,742			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:

YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YES

X

NO
16. Rental Amount for movable equipment: \$13,117Description: 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	Allocated from APEX HC Solutions		\$	\$1,791	17
18					18
19					19
20					20
21	TOTAL		\$	\$1,791	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.

Arlington Rehab & Living Center

0040899

Page 14 Supplemental

1/1/11-12/31/11

Description	Amount
Copier	6,016
Postage Machine	1,418
Allocated from APEX HC Solutions	2,538
Ice Machine	1,530
Cooler	1,265
Water Softner	350
	<u>13,117</u>

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.

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)	\$			

- (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.

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	

- (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 - 03	hrs	\$		\$ 616,853	\$		\$ 616,853	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			209,125			209,125	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			832,529			832,529	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				449,347		449,347	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					26,292	111,213		137,505	13
14	TOTAL			\$		\$ 1,684,799	\$ 560,560		\$ 2,245,359	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.

Arlington Rehab & Living Center

0040899

Page 16 Supplemental

1/1/11-12/31/11

Special Services - Supplies (Column 6 - Other)	Amount
Physical Therapy Supplies	1,398
Oxygen / Respiratory Supply Expense-Me	37,935
Laboratory Expense-Medicare A	6,000
Dme Rental Expense-Private	23,604
X-Ray Expense-Insurance	3,077
Wound Care Expense-House	39,131
Occupational Therapy Supplies	68
	<u>111,213</u>

Special Services - Outside (Column 5 - Other)	
Ambulance Expense-Private	<u>26,292</u>
	<u>26,292</u>

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 455,396	\$ 539,952	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,534,991	2,534,991	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	284,441	284,441	6
7	Other Prepaid Expenses	89,053	89,053	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	518,762	518,762	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,883,143	\$ 3,967,699	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		94,987	13
14	Buildings, at Historical Cost		3,191,253	14
15	Leasehold Improvements, at Historical Cost	1,327,415	1,327,415	15
16	Equipment, at Historical Cost	502,256	502,256	16
17	Accumulated Depreciation (book methods)	(996,251)	(1,669,316)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 833,420	\$ 3,446,595	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,716,563	\$ 7,414,294	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,796,955	\$ 1,814,681	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,019	9,019	28
29	Short-Term Notes Payable	338,695	338,695	29
30	Accrued Salaries Payable	374,088	374,088	30
31	Accrued Taxes Payable (excluding real estate taxes)	73,178	73,178	31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,937	104,937	32
33	Accrued Interest Payable	4,712	4,712	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	712,713	712,713	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,414,297	\$ 3,432,023	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,474,944	5,959,073	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,474,944	\$ 5,959,073	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,889,241	\$ 9,391,096	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,172,678)	\$ (1,976,802)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,716,563	\$ 7,414,294	48

*(See instructions.)

Arlington Rehab & Living Center

0040899

Page 17 Supplemental

1/1/11-12/31/11

Other Current Assets:	Amount	Amount
Construction in Progress	32,658	32,658
Due From Related Party	486,104	486,104
	518,762	518,762

Other Current Liabilities	Amount	Amount
Due To Related Party	312,713	312,713
Cash In Bank -Line Of Credit	400,000	400,000
	712,713	712,713

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,049,323)	1
2	Restatements (describe):		2
3	PY Equity Adjustments	515,723	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,533,600)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	510,922	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	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 360,922	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)	\$ (2,172,678)	24 *

* This must agree with page 17, line 47.

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	\$ 14,306,360	1
2	Discounts and Allowances for all Levels	(3,084,371)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,221,989	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,037,507	6
7	Oxygen	18,942	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,056,449	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	31,427	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	431,612	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,144	19
20	Radiology and X-Ray	6,149	20
21	Other Medical Services	36,137	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 577,469	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,840	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,840	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	29,548	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,548	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,897,295	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,003,018	31
32	Health Care	4,790,198	32
33	General Administration	3,041,595	33
	B. Capital Expense		
34	Ownership	1,589,250	34
	C. Ancillary Expense		
35	Special Cost Centers	2,680,903	35
36	Provider Participation Fee	281,409	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,386,373	40
41	Income before Income Taxes (line 30 minus line 40)**	510,922	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 510,922	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Arlington Rehab & Living Center
0040899
Page 19 Supplemental
1/1/11-12/31/11

Description	Amount
Rental Income (Adj. P. 5A)	8,000
Refund For 2009 Property Taxes	20,612
Jury Duty Income (Adj. P. 5A)	39
Medical Records Income (Adj. P. 5A)	886
Medicare Adjustment Income (Adj. P. 5A)	11
	<u>29,548</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	2,369	2,496	\$ 118,108	\$ 47.32	1
2	Assistant Director of Nursing	1,816	2,020	74,079	36.67	2
3	Registered Nurses	27,809	30,345	993,039	32.72	3
4	Licensed Practical Nurses	42,096	43,285	1,116,820	25.80	4
5	CNAs & Orderlies	104,449	110,244	1,564,310	14.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,070	8,704	177,100	20.35	8
9	Activity Director	1,516	1,557	29,808	19.14	9
10	Activity Assistants	17,293	18,513	194,461	10.50	10
11	Social Service Workers	6,408	6,803	150,073	22.06	11
12	Dietician					12
13	Food Service Supervisor	454	485	10,385	21.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	39,072	43,465	525,575	12.09	15
16	Dishwashers					16
17	Maintenance Workers	4,513	4,637	73,635	15.88	17
18	Housekeepers	22,986	25,076	250,469	9.99	18
19	Laundry	6,524	6,933	63,960	9.23	19
20	Administrator	2,149	2,215	130,740	59.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,833	12,244	214,596	17.53	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	2,441	2,551	56,717	22.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9,293	10,101	170,259	16.86	33
34	TOTAL (lines 1 - 33)	306,091	331,674	\$ 5,914,134 *	\$ 17.83	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 29,347	01-03	35
36	Medical Director	Monthly	54,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant		1,011	10-03	38
39	Pharmacist Consultant	Monthly	11,666	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	58	3,416	11-03	44
45	Social Service Consultant	48	1,414	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	106	\$ 101,154		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		2,520	10-03	52
53	TOTAL (lines 50 - 52)		\$ 2,520		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Arlington Rehab & Living Center

0040899

Page 20 Supplemental

1/1/11-12/31/11

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing	6,163	6,544	143,275	21.89
Bistro	3,130	3,557	26,984	7.59
	9,293	10,101	170,259	16.86

Facility Name & ID Number		Arlington Rehab & Living Center		STATE OF ILLINOIS		Report Period Beginning:		01/01/2011		Ending: 12/31/2011	
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
David Zaruba		Administrator		\$ 130,740	Workers' Compensation Insurance		\$ 121,316	IDPH License Fee		\$	
					Unemployment Compensation Insurance		44,833	Advertising: Employee Recruitment			
					FICA Taxes		372,807	Health Care Worker Background Check		230	
					Employee Health Insurance		208,224	(Indicate # of checks performed 23)			
					Employee Meals		4,105	Patient Background Checks		513	
					Illinois Municipal Retirement Fund (IMRF)*			Advertising & Promotion		25,916	
					Dental Insurance		6,491	Dues & Subscriptions		2,794	
					Vision Insurance		624	License, Inspection, & Fees		20,763	
					Other Employee Benefits		8,785	Allocated from APEX HC Solutions		8,615	
					Holiday Expense		1,856	Less: Public Relations Expense		()	
					401k Matching Expense		14,351	Non-allowable advertising		(25,916)	
					Unemployment Compensation		1,837	Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 130,740	TOTAL (agree to Schedule V, line 22, col.8)		\$ 785,229	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 37,527	
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
APEX HC Solutions - Management Fees				\$ 730,669					Out-of-State Travel		\$ 5,680
									In-State Travel		
									Seminar Expense		3,302
									Allocated from APEX HC Solutions		2,632
									Entertainment Expense		()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 730,669					(agree to Sch. V, line 24, col. 8)		
C. Professional Services									TOTAL		\$ 11,614
Vendor/Payee		Type		Amount							
Frost Ruttenberg & Rothblatt		Accounting		\$ 28,539							
Ronald Borden & Co Ltd		Accounting		24,935							
Various		Legal		4,521							
American Data		Computer Services		5,644							
MDI Achieve		Computer Software		9,638							
Health Data Systems		Computer Services		5,475							
Emdeon Business		Computer Services		1,610							
Scott Lankford		Computer Services		836							
CDW		Computer Services		2,971							
APEX Healthcare Solutions		Computer Services		1,918							
Health Data Solutions		Computer Services		3,206							
See Supplemental Schedule				10,529							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 99,822	TOTAL		\$				
* Attach copy of IMRF notifications											
**See instructions.											

* Attach copy of IMRF notifications

**See instructions.

Arlington Rehab & Living Center
0040899
Page 21 Supplemental
1/1/11-12/31/11

C. Professional Services

Vendor/Payee	Type	Amount
Computerized Business	Computer Services	1,368
Ivan's Inc.	Computer Services	4,755
Thomas Braje	Computer Services	661
Illini Tech Services	Data Recovery	361
Life Safety Resources	Life Safety Consultant	2,669
Bono Consulting	Detail Engineering	234
Village of Long Grove	Stormwater Detention Engineering	481
		<u>10,529</u>

The Arlington Rehabilitation and Living Center
0040899
Seminar Expense
01/01/11-12/31/11

Date	G/L Acct #	Payee	Topic	Job Description	City/State	Amount
2/1/2011	90-6041-00	American Data	Training on Electronic Charting Software	Nursing Staff	On Site	1,743.00
2/28/2011	90-6041-00	Debi Jung - Cross Country Education	Dementia Management	DON and Activity Director	Milwaukee, WI	358.00
4/6/2011	90-6041-00	Debi Jung - Healthcare Management Solutions	Clinical Pathways for Successful Orthotic	Rehabilitation Nurse	Schaumburg, IL	120.00
4/30/2011	90-6041-00	David Zaruba - Barnes & Noble	Guidelines 4 Pulmon. Rehab. Prgm.	Nursing Staff	N/A - Manuals	45.00
7/4/2011	90-6041-00	Debi Jung - Barnes & Noble	Guidelines 4 Pulmon. Rehab. Prgm.	Nursing Staff	N/A - Manuals	43.00
7/4/2011	90-6041-00	Debi Jung - PESI Healthcare	Pulm. Exam & Heart/Lung Sound CD	Rehabilitation Nurse	N/A - Manuals	101.00
7/4/2011	90-6041-00	Debi Jung	Contracture Mngt Ed. For B. Simbilia	Rehabilitation Nurse	N/A - Manuals	100.00
9/1/2011	90-6041-00	American Data	Training on Electronic Charting Software	Nursing Staff	On Site	315.00
9/27/2011	90-6041-00	Mary Lofgren - Cross Country Education	Psychiatric Disorders in the Aging Population	Social Services	Rolling Meadows, IL	477.00
Related Party APEX Allocation						2,632.00
Total						<u>5,934.00</u>

The Arlington Rehabilitation and Living Center
0040899
Travel
01/01/11-12/31/11

Date	G/L Acct #	Payee	Topic	Job Description	City/State	Amount	
3/25/2011	90-6061-00	Debi Jung	Seminar	DON	Cleveland, OH	253.00	ADJ
5/17/2011	90-6061-00	COMS Interactive	Training & Implementation	COMS Training Rep	Came to Illinois for training	856.00	
7/31/2011	90-6061-00	APEX				334.00	ADJ
9/1/2011	90-6061-00	APEX	Seminar	DON	Wisconsin Dells, WI	282.00	ADJ
9/30/2011	90-6061-00	Lindsey Silberschein	Annual Meeting in NC	Various	NC	3,147.00	
10/31/2011	90-6061-00	David Zaruba	Annual Meeting in NC	Various	NC	1,073.00	
10/31/2011	90-6061-00	David Zaruba	Annual Meeting in NC	Administrator	NC	232.00	
10/31/2011	90-6061-00	Elis Car Service	Annual Meeting in NC	Various	NC	160.00	
11/30/2011	90-6061-00	Lindsey Silberschein	Annual Meeting in NC	Various	NC	13.00	
12/31/2011	90-6061-00	David Zaruba	Annual Meeting in NC	Nursing	NC	199.00	
				Adjustments		(869.00)	
				Total		<u>5,680.00</u>	

Facility Name & ID Number		Arlington Rehab & Living Center		STATE OF ILLINOIS	#	0040899	Report Period Beginning:	01/01/2011	Ending:	12/31/2011	Page 23
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? If YES, give association name and amount.			No							
(3)	Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?										
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?										
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			Yes 10 Yrs							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ 55,206 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? If YES, give effective date of lease.			No							
(9)	Are you presently operating under a sublease agreement?			YES X NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ 281,409							
(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.			\$ 4,105		Has any meal income been offset against related costs?			No Indicate the amount. \$		
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			Yes							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period.										
	c. What percent of all travel expense relates to transportation of nurses and patients?			100% Line :							
	d. Have vehicle usage logs been maintained?			Yes							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			N/A							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			N/A							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			No \$ N/A							
(17)	Has an audit been performed by an independent certified public accounting firm? 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? Attach invoices and a summary of services for all architect and appraisal fees.			N/A							