



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
	<b>A. General Services</b>										
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):* <b>Related party</b>										7
8	<b>TOTAL General Services</b>	658,338	503,527	458,263	1,620,128		1,620,128		1,620,128		8
	<b>B. Health Care and Programs</b>										
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):* <b>Related party</b>										15
16	<b>TOTAL Health Care and Programs</b>	3,026,783	216,435	76,278	3,319,496		3,319,496		3,319,496		16
	<b>C. General Administration</b>										
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):* <b>Related party</b>			121,463	121,463		121,463		121,463		27
28	<b>TOTAL General Administration</b>	324,782	24,960	2,205,606	2,555,348		2,555,348	14,176	2,569,524		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	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.

Facility Name &amp; ID Number

Alden Princeton Rehabilitation and Health Care Center, Inc. #003-6244

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
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	<b>TOTAL Ownership</b>			1,032,263	1,032,263		1,032,263	366,343	1,398,606			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>		257,984	320,885	702,057		702,057		702,057			44
45	<b>GRAND TOTAL COST</b> (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.



**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	380,524	Various	34
35	Other- Attach Schedule		Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 380,524		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Alden Princeton Rehabilitation and Health Care Center, Inc.

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 -	\$	30 1
2	Elim Deprec Exp on Pg 13 items under \$2500 -		30 2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +		6 3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +		6 4
5			5
6	Elim ABC Deprec Exp from Pg 12 series -		30 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			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	<b>Total</b>	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 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)	
	<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
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	<b>TOTAL General Administration</b>	0	14,176	0	0	0	0	0	0	0	0	0	14,176	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	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)
	<b>D. Ownership</b>												
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	<b>TOTAL Ownership</b>	0	366,343	0	0	0	0	0	0	0	0	0	366,343 37
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0 44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 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			1
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								
2			Heather Health Care Center, Inc.	Harvey	The Forum Professional	Chicago	Home Office rental	2
3			Alden-Long Grove Rehabilitation and Health Care	Long Grove				3
4			Alden-Lincoln Park Rehabilitation and Health Care	Chicago	Forum Extended Care Services	Chicago	Pharmacy	4
5			Alden-Northmoor Rehabilitation and Health Care	Chicago	Alden Management Services	Chicago	Management	5
6			Alden-Lakeland Rehabilitation and Health Care	Chicago				6
7			Alden of Old Town East, Inc.	Bloomington	Alden Gardens of Bloomington	Bloomington	Supportive Living Facility	7
8			Alden Terrace of McHenry Rehabilitation and Health Care	McHenry	Alden Garden Courts of	Des Plaines	Assisted Living/Alzheimer's	8
9			Alden - Wentworth Rehabilitation and Health Care	Chicago	Alden Courts of Waterford	Aurora	Alzheimer's Facility	9
10			Alden Estates of Naperville, Inc.	Naperville	Alden Gardens of Waterford	Aurora	Assisted Living	10
11			Alden - Valley Ridge Rehabilitation and Health Care	Bloomington	Prism Health Care Services	Schaumburg	Nursing and Durable Medical	11
12			Alden Village Health Facility for Children and Youth	Bloomington	Community Physical Therapy	Addison	Therapy Provider	12
13			Alden - Orland Park Rehabilitation and Health Care	Orland Park	Alden Bennett Construction	Chicago	General Contractor	13
14			Alden - Princeton Rehabilitation and Health Care	Chicago	Fort Medical Equipment	Fort Atkinson, WI	Nursing and Durable Medical	14
15			Alden of Old Town West, Inc.	Bloomington	Fort Healthcare, LLC	Fort Atkinson, WI	SNF w/in hospital	15
16			Alden - Town Manor Rehabilitation and Health Care	Cicero				16
17			Alden Trails, Inc.	Bloomington				17
18			Alden - Poplar Creek Rehabilitation and Health Care	Hoffman Estates				18
19			Alden - North Shore Rehabilitation and Health Care	Skokie				19
20			Alden - Des Plaines Rehabilitation and Health Care	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.	Bloomington				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

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

## 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

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 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

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	Related party-AMS		x	Working Capital																
7	Related party-FECII		x	Working Capital																
8																				
9	<b>TOTAL Facility Related</b>																			
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>																			
15	<b>TOTALS (line 9+line14)</b>																			

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.)



## 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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
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>
<b>TOTALS</b>		\$ <u>261,924.17</u>	\$ <u>261,924.17</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.

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

# 003-6244

Report Period Beginning:

1/1/2011 Ending:

12/31/2011

**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:**

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

**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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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
<b>Improvement Type**</b>										
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 preasure 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		\$ 7,382,913	\$ 241,517		\$ 253,520	\$ 12,003	\$ 5,128,755	1
2	2003	15,935		3			15,935	2
3	2003	3,339	334	10	334		2,449	3
4	2004	1,178		5			1,178	4
5	2004	1,229		5			1,229	5
6	2004	2,628	263	10	263		1,775	6
7	2004	3,945	395	10	395		2,402	7
8	2004	2,746		5			2,746	8
9	2004	5,821	582	10	582		4,074	9
10	2004	1,489	149	10	149		1,043	10
11	2004	746	75	10	75		518	11
12	2004	1,948		5			1,948	12
13	2004	1,966		10			1,966	13
14	2004	1,800		5			1,800	14
15	2004			5			1,628	15
16	2004	2,660		5			2,660	16
17	2004	1,594		5			1,594	17
18	2004	2,950		5			2,950	18
19	2004	1,865		5			1,865	19
20	2005	5,716	381	15	381		2,667	20
21	2005	3,855	386	10	386		2,187	21
22	2005	1,986		5			1,986	22
23	2005	1,763	28	5	28		1,763	23
24	2005	2,409	80	5	80		2,409	24
25	2005	1,556	79	5	79		1,556	25
26	2005	10,964	1,096	5	1,096		10,964	26
27	2005	2,511	294	5	294		2,511	27
28	2006	4,134	827	5	827		3,308	28
29	2006	5,438	1,088	5	1,088		4,352	29
30	2006	2,724		5			2,724	30
31	2006						6,376	31
32	2006						3,643	32
33	2006	3,199	640	5	640		2,080	33
34		\$ 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		\$ 7,483,008	\$ 248,214		\$ 260,217	\$ 12,003	\$ 5,227,041	1
2	2006	8,185	819	10	819		2,566	2
3	2006	21,154	2,115	10	2,115		8,989	3
4	2006	2,801	560	5	560		2,333	4
5	2006	13,500	1,350	10	1,350		5,400	5
6	2007	2,813	281	10	281		984	6
7	2007	2,589	259	10	259		1,014	7
8	2007	13,341	1,334	10	1,334		5,124	8
9	2007	2,909	291	10	291		1,115	9
10	2007			5			3,360	10
11	2007	4,305	431	10	431		1,544	11
12	2007			10			6,000	12
13	2007	3,183	318	10	318		1,087	13
14	2007			10			4,882	14
15	2007	10,135	2,027	5	2,027		6,757	15
16	2007	4,091	818	5	818		2,522	16
17	2008	3,478	348	10	348		928	17
18	2008	6,619	662	10	662		1,710	18
19	2008	2,927	293	10	293		659	19
20	2008			10			4,518	20
21	2008	3,500	140	25	140		292	21
22	2009	5,123	256	20	256		314	22
23	2009	12,763	851	15	851		1,064	23
24	2009	4,887	489	10	489		611	24
25	2009	7,016	1,403	5	1,403		2,689	25
26	2009	3,975	795	5	795		861	26
27	2009	3,529	706	5	706		1,294	27
28	2009	3,292	658	5	658		1,097	28
29	2009	10,116	674	15	674		730	29
30	2009	12,656	2,531	5	2,531		3,586	30
31	2009	6,800	680	10	680		907	31
32	2009	2,631	526	5	526		570	32
33								33
34		\$ 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		\$ 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	<b>TOTAL (lines 1 thru 33)</b>	\$ 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		\$ 7,661,324	\$ 269,830		\$ 281,833	\$ 12,003	\$ 5,302,548	1
2	2009	2,742	548	5	548		731	2
3	2009	274,071	18,271		18,271		22,839	3
4	2010	209,080	2,613	20	2,613		2,613	4
5	2010	2,725	250	10	250		250	5
6	2010	8,136	610	10	610		610	6
7	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		\$ 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	<b>TOTAL</b>				\$ _____			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	<b>TOTAL</b>		\$ _____	\$ _____	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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					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	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,120,995	\$ 2,293,226	10
<b>B. Long-Term Assets</b>				
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
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Repl resrv, CIP, S/hol</u> )	19,469	388,465	22
23	Other(specify): <u>Due from affiliates</u>		719,677	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,299,195	\$ 5,582,603	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,420,190	\$ 7,875,829	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
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
31	Accrued Taxes Payable (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
<b>Other Current Liabilities(specify):</b>				
36	<u>Accr Exp, Due HFS, Sales Tax, Etc.</u>	134,521	134,521	36
37	<u>Due to affiliates</u>	908,910	908,910	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,362,662	\$ 2,696,262	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,698,733	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
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	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 8,951,498	\$ 16,650,231	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 11,314,160	\$ 19,346,493	46
47	<b>TOTAL EQUITY (page 18, line 24)</b>	\$ (7,893,970)	\$ (11,470,664)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 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
<b>A. Additions (deductions):</b>			
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>B. Transfers (Itemize):</b>			
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.

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

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

\* 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 Health # 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: 18,747

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

# 003-6244

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type	Amount						
Alden Management Services, Inc.	Consulting	\$						
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

Report Period Beginning: 1/1/2011 Ending: 12/31/2011

**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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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

# 003-6244

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

**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. \$ \_\_\_\_\_ 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. \_\_\_\_\_
- (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 benefits 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