FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 Ctr

Address: 1666 RFD Checker Rd (Number) Long Grove (City) 60047 (Zip Code)

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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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 01/01/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # 847) 964-5469

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 Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	39,931	7,633	11,274	58,838	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,931	7,633	11,274	58,838	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.84%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 01/02/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 190 and days of care provided 6,623

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	380,347	63,527	328,593	772,467		772,467	12,667	785,134			1
2	Food Purchase		375,067		375,067		375,067	(1,116)	373,951			2
3	Housekeeping	289,373	62,473		351,846		351,846		351,846			3
4	Laundry	28,922	173,688		202,610		202,610		202,610			4
5	Heat and Other Utilities			205,329	205,329		205,329		205,329			5
6	Maintenance	95,984	46,771	137,015	279,770		279,770	1,228	280,998			6
7	Other (specify):*											7
8	**TOTAL General Services**	794,626	721,526	670,937	2,187,089		2,187,089	12,779	2,199,868			8
	B. Health Care and Programs											
9	Medical Director			68,400	68,400		68,400		68,400			9
10	Nursing and Medical Records	4,099,222	312,278	11,303	4,422,803		4,422,803	62,037	4,484,840			10
10a	Therapy		468	35,588	36,056		36,056		36,056			10a
11	Activities	181,665	6,459	5,467	193,591		193,591		193,591			11
12	Social Services	144,764	4,999	827	150,590		150,590	(4,999)	145,591			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,425,651	324,204	121,585	4,871,440		4,871,440	57,038	4,928,478			16
	C. General Administration											
17	Administrative	112,025		570,609	682,634		682,634	(524,693)	157,941			17
18	Directors Fees											18
19	Professional Services			121,429	121,429		121,429	2,661	124,090			19
20	Dues, Fees, Subscriptions & Promotions			51,001	51,001		51,001	(17,262)	33,739			20
21	Clerical & General Office Expenses	192,080	20,775	896,682	1,109,537		1,109,537	(551,457)	558,080			21
22	Employee Benefits & Payroll Taxes			714,112	714,112		714,112	60,626	774,738			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,591	22,591		22,591	2,053	24,644			24
25	Other Admin. Staff Transportation			8,802	8,802		8,802	49,097	57,899			25
26	Insurance-Prop.Liab.Malpractice			222,775	222,775		222,775	11	222,786			26
27	Other (specify):*											27
28	**TOTAL General Administration**	304,105	20,775	2,608,001	2,932,881		2,932,881	(978,964)	1,953,917			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,524,382	1,066,505	3,400,523	9,991,410		9,991,410	(909,147)	9,082,263			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 & ID Number Arlington Rehab & Living Ctr #0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			200,757	200,757		200,757	61,223	261,980			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			170,627	170,627		170,627	(170,627)				32
33	Real Estate Taxes			120,336	120,336		120,336		120,336			33
34	Rent-Facility & Grounds			1,206,150	1,206,150		1,206,150	(1,199,369)	6,781			34
35	Rent-Equipment & Vehicles			8,828	8,828		8,828	1,256	10,084			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,706,698	1,706,698		1,706,698	(1,307,517)	399,181			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		436,241	1,076,966	1,513,207		1,513,207	(44,450)	1,468,757			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			423,203	423,203		423,203		423,203			42
43	Other (specify):*	67,556		207,403	274,959		274,959	(274,959)				43
44	**TOTAL Special Cost Centers**	67,556	436,241	1,707,572	2,211,369		2,211,369	(319,409)	1,891,960			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,591,938	1,502,746	6,814,793	13,909,477		13,909,477	(2,536,073)	11,373,404			45

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	(37,984)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(57,613)	30		9
10	Interest and Other Investment Income	(69,998)	32		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	(815)	21		18
19	Entertainment	(274)	21		19
20	Contributions	(400)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(787,402)	21		24
25	Fund Raising, Advertising and Promotional	(24,747)	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	(406,759)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,385,992)		$	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 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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,385,992)		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

Arlington Rehab & Living Ctr

ID# 0040899

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Period Income Adjustment	$ 390	21	1
2	Incontinence Revenue	(10,069)	10	2
3	Patient Needs	(4,999)	12	3
4	Non-Allowable Legal	(207,403)	43	4
5	Public Relations	(530)	20	5
6	Bank Charges	(11,028)	21	6
7	Credit Card Processing Fees	(1,488)	21	7
8	Franchise Tax	(2,851)	21	8
9	Vending Commissions	(1,116)	02	9
10	Marketing Wages	(67,556)	43	10
11	Non-Allowable Interest (Related Party)	(100,109)	32	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(406,759)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Arlington Rehab & Living Ctr **#** 0040899 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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)	
	A. General Services													
1	Dietary	0	0	0	12,667	0	0	0	0	0	0	0	12,667	1
2	Food Purchase	(1,116)	0	0	0	0	0	0	0	0	0	0	(1,116)	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	1,228	0	0	0	0	0	0	0	1,228	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,116)	0	0	13,895	0	0	0	0	0	0	0	12,779	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(10,069)	0	0	72,106	0	0	0	0	0	0	0	62,037	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	(4,999)	0	0	0	0	0	0	0	0	0	0	(4,999)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(15,068)	0	0	72,106	0	0	0	0	0	0	0	57,038	16
	C. General Administration													
17	Administrative	0	0	0	(524,693)	0	0	0	0	0	0	0	(524,693)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	2,661	0	0	0	0	0	0	0	2,661	19
20	Fees, Subscriptions & Promotions	(25,277)	0	0	8,015	0	0	0	0	0	0	0	(17,262)	20
21	Clerical & General Office Expenses	(841,852)	0	0	290,395	0	0	0	0	0	0	0	(551,457)	21
22	Employee Benefits & Payroll Taxes	0	0	0	60,626	0	0	0	0	0	0	0	60,626	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	2,053	0	0	0	0	0	0	0	2,053	24
25	Other Admin. Staff Transportation	0	0	0	49,097	0	0	0	0	0	0	0	49,097	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	11	0	0	0	0	0	0	0	11	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(867,129)	0	0	(111,835)	0	0	0	0	0	0	0	(978,964)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(883,313)	0	0	(25,834)	0	0	0	0	0	0	0	(909,147)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(57,613)	116,034	0	2,802	0	0	0	0	0	0	0	61,223	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(170,107)	(520)	0	0	0	0	0	0	0	0	0	(170,627)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,206,150)	0	6,781	0	0	0	0	0	0	0	(1,199,369)	34
35	Rent-Equipment & Vehicles	0	0	0	1,256	0	0	0	0	0	0	0	1,256	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(227,720)	(1,090,636)	0	10,839	0	0	0	0	0	0	0	(1,307,517)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(44,450)	0	0	0	0	0	0	0	0	(44,450)	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):*	(274,959)	0	0	0	0	0	0	0	0	0	0	(274,959)	43
44	**TOTAL Special Cost Centers**	(274,959)	0	(44,450)	0	0	0	0	0	0	0	0	(319,409)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,385,992)	(1,090,636)	(44,450)	(14,995)	0	0	0	0	0	0	0	(2,536,073)	45

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 Schedule						

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,206,150	Kedzie Home, LLC	100.00%	$	$ (1,206,150)	1
2	V	30	Depreciation		Kedzie Home, LLC	100.00%	116,034	116,034	2
3	V	32	Interest Expense	520	Kedzie Home, LLC	100.00%		(520)	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			$ 1,206,670			$ 116,034	$ * (1,090,636)	14

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary Rehab	$ 1,064,303	Simply Rehab		$ 1,019,853	$ (44,450)	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			$ 1,064,303			$ 1,019,853	$ * (44,450)	39

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Consultant	$	APEX Healthcare Solutions, LLC	100.00%	$ 12,667	$ 12,667	15
16	V	6	Building Supplies		APEX Healthcare Solutions, LLC	100.00%	1,228	1,228	16
17	V	10	Nursing Salaries		APEX Healthcare Solutions, LLC	100.00%	72,106	72,106	17
18	V	17	Administrative Salaries - Owners		APEX Healthcare Solutions, LLC	100.00%	40,902	40,902	18
19	V	17	Management Fees		APEX Healthcare Solutions, LLC	100.00%	5,014	5,014	19
20	V	19	Professional Fees		APEX Healthcare Solutions, LLC	100.00%	2,661	2,661	20
21	V	20	Dues, Fees, Subscriptions		APEX Healthcare Solutions, LLC	100.00%	8,015	8,015	21
22	V	21	G&A		APEX Healthcare Solutions, LLC	100.00%	290,395	290,395	22
23	V	22	Employee Benefits		APEX Healthcare Solutions, LLC	100.00%	60,626	60,626	23
24	V	24	Seminars		APEX Healthcare Solutions, LLC	100.00%	2,053	2,053	24
25	V	25	Auto & Travel		APEX Healthcare Solutions, LLC	100.00%	49,097	49,097	25
26	V	26	Insurance		APEX Healthcare Solutions, LLC	100.00%	11	11	26
27	V	30	Depreciation		APEX Healthcare Solutions, LLC	100.00%	2,802	2,802	27
28	V	34	Rent		APEX Healthcare Solutions, LLC	100.00%	6,781	6,781	28
29	V	35	Equipment Rental		APEX Healthcare Solutions, LLC	100.00%	1,256	1,256	29
30	V								30
31	V	17	Management Fees	570,609	APEX Healthcare Solutions, LLC	100.00%		(570,609)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 570,609			$ 555,614	$ * (14,995)	39

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Doughtery, Gayle	17.14%	Aurora Rehabilitation Center	Aurora, IL	Kedzie Home	Chicago, IL	Building Co.	1
2	Lawton, Shelly Loyd	17.14%	Kolob - Cedar City	Cedar City, UT	APEX Healthcare Solu	Buffalo Grove, IL	Management	2
3	Veronica H. Lefokovitz Dynasty Trust	17.14%	Kolob - St. George	St. George, UT	Simply Rehab	Northbrook, IL	Therapy	3
4	Mann, James	10.20%	Carver Living Center	Durham, NC	Aurora Supportive Liv	Aurora, IL	SLF	4
5	Mann, Nina	17.14%	Willow Ridge	Rutherfordton, NC	Coles Supportive Livir	Chicago, IL	SLF	5
6	Thomas & Donna Neshek Revocable Trust	17.14%	Pineville Rehabilitation & Living Center	Pineville, NC	Jackson Park Support	Chicago, IL	SLF	6
7	Papas, Patricia	1.02%	Ridgewood RLC, LLC	Washington, NC	Robbins Supportive L	Robbins, IL	SLF	7
8	Rosenberg, Sheldon	3.06%	Broomfield Skilled Nursing	Broomfield, CO	Rockford Supportive I	Rockford, IL	SLF	8
9			Crown Crest of Parker	Parker, CO				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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aaron Mann	Director of Operation	Administrative		See Attached	4.9	0.12	Alloc. Salary	$ 38,472	17-7	1
2	Sam Neshek	Relative	Administrative		See Attached	5.4	0.14	Alloc. Salary	2,372	17-7	2
3	Jamey Dougherty	Relative	Administrative		See Attached	1.1	0.03	Alloc. Salary	2,020	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 42,864		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 Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 [X]

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 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						$	$		$	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 Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 [X] 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		$ 1,019,853	$	190	$ 1,019,853	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					$ 1,019,853	$		$ 1,019,853	25

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

Name of Related Organization: APEX Healthcare Solutions, LLC
Street Address: 1425 McHenry Rd., Site 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	1	Dietary Consultant	Mgt. Fees/Days	433,289	10	$ 93,283	$ 98,283	58,838	$ 12,667	1
2	6	Building Supplies	Mgt. Fees/Days	433,289	15	9,045		58,838	1,228	2
3	10	Nursing Salaries	Mgt. Fees/Days	433,289	10	530,995	530,995	58,838	72,106	3
4	17	Administrative Salaries - Owners	Direct/Days	433,289	15	528,636	528,636	58,838	40,902	4
5	17	Management Fees	Mgt. Fees/Days	433,289	15	36,927		58,838	5,014	5
6	19	Professional Fees	Mgt. Fees/Days	433,289	15	19,592		58,838	2,660	6
7	20	Dues, Fees, Subscriptions	Direct/Days	433,289	15	59,023		58,838	8,015	7
8	21	G&A	Mgt. Fees/Days	433,289	15	2,138,500	2,058,307	58,838	290,395	8
9	22	Employee Benefits	Mgt. Fees/Days	433,289	15	409,591		58,838	60,626	9
10	24	Seminars	Mgt. Fees/Days	433,289	15	15,117		58,838	2,053	10
11	25	Auto & Travel	Mgt. Fees/Days	433,289	15	361,553		58,838	49,097	11
12	26	Insurance	Mgt. Fees/Days	433,289	15	84		58,838	11	12
13	30	Depreciation	Mgt. Fees/Days	433,289	15	20,636		58,838	2,802	13
14	34	Rent	Mgt. Fees/Days	433,289	15	49,937		58,838	6,781	14
15	35	Equipment Rental	Mgt. Fees/Days	433,289	15	9,251		58,838	1,256	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,282,170	$ 3,216,221		$ 555,613	25

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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				1,277,642			126,773	6
7	Venture Fund	X		Working Capital				3,090,548			43,854	7
8												8
9	TOTAL Facility Related						$	$ 4,368,190			$ 170,627	9
	B. Non-Facility Related*											
10	Interest Income		X								(69,998)	10
11	Venture Fund (Bldg. Co.)	X		Mortgage				2,447,846				11
12	Interest Income		X								(520)	12
13	Non-Allowable Int. Adj. P5	X									(100,109)	13
14	TOTAL Non-Facility Related						$	$ 2,447,846			$ (170,627)	14
15	TOTALS (line 9+line14)						$	$ 6,816,036			$	15

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

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

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	114,764	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.)	$	114,683	2
3. Under or (over) accrual (line 2 minus line 1).	$	(81)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	120,417	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.	$	120,336	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	119,309	8
	2009	123,119	9
	2010	99,940	10
	2011	109,299	11
	2012	114,683	12

2013 Accraul = $114,683 x 1.05% = $120,417

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIO	$	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.**

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arlington Rehab & Living Ctr COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0040899

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of th cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-31-201-082	Long-Term Care Property	$ 107,618.21	$ 107,618.21
2.	15-31-201-083	Long-Term Care Property	$ 7,064.63	$ 7,064.63
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 114,682.84	$ 114,682.84

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,302 B. General Construction Type: Exterior Drivit/Face Brick Frame Cinder Block Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	31,575		20	1,515	1,515	27,944	9
10	Various			1997	34,251		20	1,713	1,713	26,089	10
11	Various			1998	115,118		20	5,756	5,756	88,333	11
12	Various			1999	8,794		20	440	440	5,950	12
13	Various			2000	5,943		20	41	41	5,658	13
14	Various			2001	11,296		20	565	565	7,089	14
15	Various			2002	41,668		20			41,668	15
16	Various			2003	12,640		20	632	632	12,390	16
17	Various			2004	102,912		20	5,146	5,146	92,767	17
18	Various			2005	443,003		20	22,150	22,150	194,559	18
19	Various			2006	122,772		20	6,139	6,139	77,883	19
20	Various			2007	524,838		20	26,242	26,242	172,629	20
21	Various			2008	1,557,905		20	77,895	77,895	455,308	21
22	Various			2009	447,975		20	22,399	22,399	104,201	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	Related Party Allocations					2,802			(2,802)		35
36	Total Book Depreciation					200,757					36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	
37	WALL CONSTRUCTION	2010	$ 6,292	$	20	$ 315	$ 315	$ 1,260	37
38	SINK & DRAIN	2010	6,815		20	341	341	1,364	38
39	BOILER HEAT EXCHANGE	2010	3,608		20	180	180	1,143	39
40	BOILER	2010	3,269		20	163	163	639	40
41	FIRE DAMPERS	2010	4,943		20	247	247	947	41
42	DEEP WELL PUMP	2010	8,945		20	447	447	1,676	42
43	PULL PIPE & MOTOR	2010	29,117		20	1,456	1,456	8,978	43
44	SITE SURVEY	2010	4,993		20	250	250	833	44
45	SURVEY REPAIRS, FANS	2010	5,251		20	263	263	855	45
46	WATER PLANT WALL	2010	7,719		20	386	386	1,222	46
47	HINGES, COOLER DUCTING	2010	9,689		20	484	484	1,492	47
48	Well Pump/Piping - CR Only	2011	2,569		20	128	128	320	48
49	Well Pump Mototr - CR Only	2011	3,984		20	199	199	481	49
50	Elevator Repair - CR Only	2011	2,850		20	143	143	310	50
51	Elevator Repair - CR Only	2011	2,850		20	143	143	310	51
52	Hot Water Storage Tanks	2012	8,900		20	445	445	890	52
53	Fire Alarm System	2012	92,292		20	4,615	4,615	8,845	53
54	Computer Room Cooler	2012	3,065		20	153	153	293	54
55	Heat Exchanger	2012	1,736		20	87	87	160	55
56	Laundry Heat Exchanger	2012	3,135		20	157	157	288	56
57	Electrical Wiring	2012	2,166		20	108	108	189	57
58	Lighting and Electrical Work	2012	4,569		20	228	228	249	58
59	Leasehold/Land Improvements	2012	92,954		20	4,648	4,648	5,071	59
60	Chain Link Fence	2013	1,471		20	31	31	31	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,773,872	$ 203,559		$ 186,250	$ 183,448	$ 1,350,314	70

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 12A, Carried Forward		$ 3,773,872	$ 203,559		$ 186,250	$ (17,309)	$ 1,350,314	1
2	Building Company Information:								2
3									3
4	Building	1996	20,105						4
5	Building	1995	5,614,638						5
6	East Addition	2008	160,181						6
7	Building Company Book Depreciation			116,034			(116,034)	905,133	7
8									8
9									9
10	Leasehold Improvements:								10
11	Building Supplies	2008	4,371		20	219	219	876	11
12	Remodel Bathing Area in Room 344	2008	13,770		20	689	689	2,756	12
13	Architectural Services	2008	9,874		20	494	494	1,976	13
14	Remodel Shower Rooms 517 and 519	2008	4,407		20	220	220	880	14
15	Construction - Home Depot	2008	4,690		20	235	235	940	15
16	Electric Work	2008	37,907		20	1,895	1,895	7,580	16
17	Furnish & Install one stair Assembly with Header	2008	4,400		20	220	220	880	17
18	Framing, Drywall Hanging and Painting New Partitions	2008	103,064		20	5,153	5,153	20,612	18
19	Concrete Floor Opening	2008	4,600		20	230	230	920	19
20	East Addition and Wing 300 Remodeling	2008	25,853		20	1,293	1,293	5,172	20
21	Exhaust System	2008	14,386		20	719	719	2,876	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)		$ 9,796,118	$ 319,593		$ 197,617	$ (121,976)	$ 2,300,915	34

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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 593,919	$	$ 59,392	$ 59,392	10	$ 360,924	71
72	Current Year Purchases	8,292		293	293	10	293	72
73	Fully Depreciated Assets	704,741		361	361		704,741	73
74	Allocated Mgt. Co.							74
75	TOTALS	$ 1,306,952	$	$ 60,046	$ 60,046		$ 1,065,958	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		4,317	4,317	5	25,900	78
79										79
80	TOTALS			$ 116,620	$	$ 4,317	$ 4,317		$ 116,620	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,391,882	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 319,593	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 261,980	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (57,613)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,483,493	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	CIP	$ 69,697	92
93			93
94			94
95		$ 69,697	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.

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from APEX HC Solutions, LLC				6,781			5
6								6
7	TOTAL				$ 6,781 **			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: ____ *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 8,828 Description: See Attached
(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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	$		$ 425,821	$		$ 425,821	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			66,538			66,538	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			582,090			582,090	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				288,493		288,493	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-03				2,517			2,517	12
13	Other (specify): See Attached	39-02					147,748		147,748	13
14	TOTAL			$		$ 1,076,966	$ 436,241		$ 1,513,207	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.

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 448,026	$ 449,311	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,663,965	3,663,965	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	250,629	250,629	6
7	Other Prepaid Expenses	14,202	14,202	7
8	Accounts Receivable (owners or related parties)		9,320	8
9	Other(specify): See Attached	450,722	456,367	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,828,044	$ 4,844,294	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		94,987	13
14	Buildings, at Historical Cost		3,191,252	14
15	Leasehold Improvements, at Historical Cost	1,529,767	1,529,767	15
16	Equipment, at Historical Cost	538,165	538,165	16
17	Accumulated Depreciation (book methods)	(1,381,525)	(2,286,658)	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): See Attached	123,027	123,027	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 809,434	$ 3,190,540	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,637,478	$ 8,034,834	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,439,634	$ 3,439,634	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	919,803	919,803	29
30	Accrued Salaries Payable	364,433	364,433	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,898	29,898	31
32	Accrued Real Estate Taxes(Sch.IX-B)	120,417	120,417	32
33	Accrued Interest Payable	116,857	116,857	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	565,587	565,587	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,556,629	$ 5,556,629	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,488,387	5,936,233	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)**	$ 3,488,387	$ 5,936,233	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,045,016	$ 11,492,862	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,407,538)	$ (3,458,028)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,637,478	$ 8,034,834	48

***(See instructions.)**

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,768,755)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,768,755)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,638,783)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,638,783)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,407,538)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,704,628	1
2	Discounts and Allowances for all Levels	(1,797,401)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,907,227	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,896,541	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,896,541	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	1,116	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	299,229	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,410	19
20	Radiology and X-Ray	4,784	20
21	Other Medical Services	72,389	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 396,928	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	69,998	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 69,998	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,270,694	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,187,089	31
32	Health Care	4,871,440	32
33	General Administration	2,932,881	33
	B. Capital Expense		
34	Ownership	1,706,698	34
	C. Ancillary Expense		
35	Special Cost Centers	1,788,166	35
36	Provider Participation Fee	423,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,909,477	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,638,783)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,638,783)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,938,964	44
45	Private Pay - Net Inpatient Revenue	1,626,706	45
46	Medicare - Net Inpatient Revenue	1,542,690	46
47	Other-(specify) **Ins./Medicare Replacement**	250,017	47
48	Other-(specify) **Hospice**	548,850	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,907,227	49

* **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.**

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$ 85,010	$	1
2	Assistant Director of Nursing			73,828		2
3	Registered Nurses			922,996		3
4	Licensed Practical Nurses	40,497	42,336	1,329,089	31.39	4
5	CNAs & Orderlies	116,667	123,757	1,642,803	13.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	15,348	15,908	181,665	11.42	10
11	Social Service Workers	5,815	6,327	144,764	22.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,002	32,132	380,347	11.84	15
16	Dishwashers					16
17	Maintenance Workers	5,347	5,722	95,984	16.77	17
18	Housekeepers	26,548	28,033	289,373	10.32	18
19	Laundry	2,666	2,844	28,922	10.17	19
20	Administrator	3,359	3,559	112,025	31.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,725	10,139	192,080	18.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,809	1,824	45,496	24.94	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing Wages	2,112	2,288	67,556	29.53	33
34	TOTAL (lines 1 - 33)	260,895	274,869	$ 5,591,938 *	$ 20.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 328,593	1-3	35
36	Medical Director	Monthly	68,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,303	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	35,588	10A-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	94	5,467	11-3	44
45	Social Service Consultant	15	827	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	109	$ 450,178		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator Reimbursed Wage	Administrator	0	$ 31,130
Administrator Wages	Administrator	0	80,895
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 112,025

B. Administrative - Other

Description	Amount
APEX HC Solutions, LLC - Management Fees	$ 570,609
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 570,609

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Data Processing	$ 250
American Data	Data Processing	6,120
Apex Healthcare Solutions	Data Processing	9,138
Comcast	Data Processing	4,569
COMS Interactive	Data Processing	21,059
E-Health Data Solutions	Data Processing	5,296
EMDEON Business Svc.	Data Processing	384
Health Data Systems, Inc.	Computer Services	1,310
IVANS, Inc	Data Processing	4,142
Personnel Planners	Unemployment Consultant	2,054
Richter Healthcare Consultants	AR/Consultants	16,016
See Attached		51,091
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 121,429

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,938
Unemployment Compensation Insurance	67,723
FICA Taxes	422,757
Employee Health Insurance	163,757
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	7,405
Other Employee Benefits	23,918
Supplemental Insurance	10,232
401K Matching Expense	10,382
TOTAL (agree to Schedule V, line 22, col.8)	$ 714,112

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	14,900
Health Care Worker Background Check	
(Indicate # of checks performed 114.5)	1,260
Patient Background Checks 195	1,950
Public Relations	530
Dues & Subscriptions	2,548
Advertsing & Promotion	24,747
Licenses & Fees	3,076
Alloacted - APEX	8,015
Less: Public Relations Expense	(530)
Non-allowable advertising	(24,747)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,739

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	21,568
Seminar Expense	3,076
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,644

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Arlington Rehab & Living Ctr # 0040899 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,011** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **423,203**
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? **Yes** Indicate the amount. $ **1,116**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Line 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.