

		FOR OHF USE				

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0042077</u></p> <p><b>Facility Name:</b> <u>ALDEN OF OLD TOWN WEST</u></p> <p><b>Address:</b> <u>118 S BLOOMINGDALE RD</u> <u>BLOOMINGDALE</u> <u>60108</u>  Number City Zip Code</p> <p><b>County:</b> <u>DUPAGE</u></p> <p><b>Telephone Number:</b> <u>(630) 671-1660</u> Fax # <u>(630) 671-0457</u></p> <p><b>IDPA ID Number:</b> <u>36-3966583</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>05/19/98</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>STEVEN M. KROLL</u> Telephone Number: <u>(773) 286-3883</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>STEVEN M. KROLL</u></td> </tr> <tr> <td></td> <td>(Title) <u>CHIEF OPERATING OFFICER</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>STEVEN M. KROLL</u>		(Title) <u>CHIEF OPERATING OFFICER</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
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	(Firm Name & Address) _____																																						
	(Telephone) <u>( )</u> Fax # ( )																																						

Facility Name & ID Number ALDEN OF OLD TOWN WEST

# 0042077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**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	16	Skilled (SNF)		5,856	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	16	TOTALS		5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	5,506			5,506	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,506			5,506	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.02%

D. How many bed-hold days during this year were paid by Public Aid? 158 (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 05/19/98

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/19/98 NO

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 01/01/00 Fiscal Year: 12/31/00

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

STATE OF ILLINOIS

Facility Name & ID Number ALDEN OF OLD TOWN WEST # 0042077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	63,356	2,950		66,306		66,306		66,306		1
2	Food Purchase		34,945		34,945	(8,426)	26,519		26,519		2
3	Housekeeping	9,025	4,017		13,042	106	13,148		13,148		3
4	Laundry		1,600		1,600		1,600		1,600		4
5	Heat and Other Utilities			14,919	14,919		14,919		14,919		5
6	Maintenance			20,246	20,246	1,438	21,684	891	22,575		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	72,381	43,512	35,165	151,058	(6,882)	144,176	891	145,067		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,200	5,200		5,200		5,200		9
10	Nursing and Medical Records	284,572	12,897	1,346	298,815		298,815	1,263	300,078		10
10a	Therapy										10a
11	Activities		110		110		110	336	446		11
12	Social Services	6,097		4,244	10,341		10,341		10,341		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	290,669	13,007	10,790	314,466		314,466	1,599	316,065		16
	<b>C. General Administration</b>										
17	Administrative	14,573			14,573		14,573		14,573		17
18	Directors Fees										18
19	Professional Services			96,164	96,164		96,164	(89,374)	6,790		19
20	Dues, Fees, Subscriptions & Promotions			7,381	7,381	(1,438)	5,943	(3,885)	2,058		20
21	Clerical & General Office Expenses	49,155	1,604	8,276	59,035		59,035	8,073	67,108		21
22	Employee Benefits & Payroll Taxes			60,915	60,915	8,320	69,235	4,256	73,491		22
23	Inservice Training & Education										23
24	Travel and Seminar			63	63		63	1,450	1,513		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			2,638	2,638		2,638	15	2,653		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	63,728	1,604	175,437	240,769	6,882	247,651	(79,465)	168,186		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	426,778	58,123	221,392	706,293		706,293	(76,975)	629,318		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 ALDEN OF OLD TOWN WEST #0042077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			2,883	2,883		2,883	43,745	46,628			30
31	Amortization of Pre-Op. & Org.							10	10			31
32	Interest			38,745	38,745		38,745	69,215	107,960			32
33	Real Estate Taxes			15,799	15,799		15,799	629	16,428			33
34	Rent-Facility & Grounds			91,213	91,213		91,213	(91,213)				34
35	Rent-Equipment & Vehicles			2,620	2,620		2,620	1,988	4,608			35
36	Other (specify):* <b>mortg. Insur.</b>							4,329	4,329			36
37	<b>TOTAL Ownership</b>			151,260	151,260		151,260	28,703	179,963			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		449		449		449	(1,391)	(942)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,870	32,870		32,870		32,870			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		449	32,870	33,319		33,319	(1,391)	31,928			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	426,778	58,572	405,522	890,872		890,872	(49,663)	841,209			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 ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

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	OHF 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	(59)	32		18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,030)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(861)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (4,000)</b>		<b>\$</b>	<b>30</b>

OHF 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)	(47,309)		34
35	Other- Attach Schedule	1,646		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (45,663)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (49,663)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

ID# 0042077  
Report Period Beginning: 01/01/00  
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
			10
1	disallow prior-year adj for salaries-don	\$ 1,310	1
2	disallow prior-year adj for salaries-occup rehab	336	2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
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76			76
77			77
78			78
79			79
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81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	<b>Total</b>	1,646	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ALDEN OF OLD TOWN WEST

# 0042077 Report Period Beginning:

01/01/00

Ending:

12/31/00

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	891	0	0	0	0	0	0	0	0	891	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>891</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>891</b>	<b>8</b>
	<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	1,310	0	0	0	(47)	0	0	0	0	0	0	1,263	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	336	0	0	0	0	0	0	0	0	0	0	336	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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>	<b>1,646</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(47)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,599</b>	<b>16</b>
	<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	0	(89,353)	0	0	0	0	(21)	0	0	0	(89,374)	19
20	Fees, Subscriptions & Promotions	(3,941)	0	56	0	0	0	0	0	0	0	0	(3,885)	20
21	Clerical & General Office Expenses	0	4,187	3,739	73	74	0	0	0	0	0	0	8,073	21
22	Employee Benefits & Payroll Taxes	0	0	4,464	0	(208)	0	0	0	0	0	0	4,256	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,450	0	0	0	0	0	0	0	0	1,450	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	0	15	0	0	0	0	0	0	0	0	15	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(3,941)</b>	<b>4,187</b>	<b>(79,629)</b>	<b>73</b>	<b>(134)</b>	<b>0</b>	<b>0</b>	<b>(21)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(79,465)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(2,295)</b>	<b>4,187</b>	<b>(78,738)</b>	<b>73</b>	<b>(181)</b>	<b>0</b>	<b>0</b>	<b>(21)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(76,975)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN OF OLD TOWN WEST# 0042077 Report Period Beginning:01/01/00 Ending:12/31/00

## 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	28,430	15,315	0	0	0	0	0	0	0	0	43,745 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	10	0	0	0	0	10 31
32	Interest	(59)	68,750	508	0	0	0	16	0	0	0	0	69,215 32
33	Real Estate Taxes	0	0	629	0	0	0	0	0	0	0	0	629 33
34	Rent-Facility & Grounds	0	(91,213)	0	0	0	0	0	0	0	0	0	(91,213) 34
35	Rent-Equipment & Vehicles	0	0	1,988	0	0	0	0	0	0	0	0	1,988 35
36	Other (specify):*	0	4,329	0	0	0	0	0	0	0	0	0	4,329 36
37	<b>TOTAL Ownership</b>	<b>(59)</b>	<b>10,296</b>	<b>18,440</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>26</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28,703 37</b>
	<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	(360)	(11)	0	(1,020)	0	0	0	0	(1,391) 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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(360)</b>	<b>(11)</b>	<b>0</b>	<b>(1,020)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,391) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(2,354)</b>	<b>14,483</b>	<b>(60,298)</b>	<b>(287)</b>	<b>(192)</b>	<b>0</b>	<b>(994)</b>	<b>(21)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(49,663) 45</b>

Facility Name &amp; ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.		SEE PG 6K...		SEE PG 6K...		

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	\$ 91,213	BLOOMINGDALE ASSOC.	0.00%	\$	\$ (91,213)	1
2	V	32 INTEREST INCOME	252	BLOOMINGDALE ASSOC.			(252)	2
3	V	21 G&A		BLOOMINGDALE ASSOC.		4,187	4,187	3
4	V	36 MORTGAGE INSUR.		BLOOMINGDALE ASSOC.		4,329	4,329	4
5	V	30 DEPRECIATION		BLOOMINGDALE ASSOC.		28,430	28,430	5
6	V	32 MORTGAGE INTEREST				69,002	69,002	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 91,465			\$ 105,948	\$ * 14,483	14

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

Facility Name & ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 maintenance/utilities	\$	Alden Management Services, Inc.	100.00%	\$ 891	\$ 891
16	V	19 professional fees	90,574	Alden Management Services, Inc.		1,221	(89,353)
17	V	20 licenses/fees		Alden Management Services, Inc.		56	56
18	V	21 gen'l & admin		Alden Management Services, Inc.		3,739	3,739
19	V	22 employee costs		Alden Management Services, Inc.		4,464	4,464
20	V	24 auto/seminar		Alden Management Services, Inc.		1,450	1,450
21	V	26 insurance		Alden Management Services, Inc.		15	15
22	V	30 depreciation		Alden Management Services, Inc.		15,315	15,315
23	V	32 interest		Alden Management Services, Inc.		508	508
24	V	33 real estate tax		Alden Management Services, Inc.		629	629
25	V	35 auto lease		Alden Management Services, Inc.		1,988	1,988
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 90,574			\$ 30,276	\$ * (60,298)

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

Facility Name & ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V	2 tube feeding	\$	Pyramid Health Care Services	0.00%	\$	\$	15	
16	V	39 nursing supplies	360	Pyramid Health Care Services			(360)	16	
17	V	39 supplies/per diem fees/misc		Pyramid Health Care Services				17	
18	V	21 gen'l & admin		Pyramid Health Care Services		73	73	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		\$ 360			\$ 73	\$ *	(287)	39

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

Facility Name & ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

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	10 house stock	\$ 192	Forum Extended Care II	0.00%	\$ 145	\$ (47)
16	V	39 iv	45	Forum Extended Care II		34	(11)
17	V	22 vaccinations	839	Forum Extended Care II		631	(208)
18	V	21 gen'l & admin		Forum Extended Care II		74	74
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,076			\$ 884	\$ * (192)

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

Facility Name & ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 THERAPY	\$ 1,422	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 402	\$ (1,020)	15
16	V	31 AMORTIZATION		COMMUNITY PHYSICAL THERAPY		10	10	16
17	V	32 INTEREST		COMMUNITY PHYSICAL THERAPY		16	16	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		\$ 1,422			\$ 428	\$ * (994)	39

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

Facility Name & ID Number ALDEN OF OLD TOWN WEST

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Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
15	V	19 construction management fee	\$ 1,513	Alden Bennett Construction	0.00%	\$ 1,492	\$ (21)
16	V	19 architect/design fee	54	Alden Design Group		54	
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,567			\$ 1,546	\$ * (21)

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

Facility Name & ID Number ALDEN OF OLD TOWN WEST # 0042077 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 Schlossberg	President-AMS	CEO	100.00	193,342	0.228	0.57	salary	\$ 1,104	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	74,067	0.228	0.57	salary	423	21-1	2
3	Terry Magnusson	Administrator/other	admin/mainten.	b.	73,446	0.228	0.57	salary	174	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6,851	0	0.00	fee	0	10a-3	4
5											5
6											6
7											7
8											8
9											9
10	a. Lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000.										10
11	b. Terry is the son-in-law of Floyd Schlossberg.He was the administrator of Alden Valley Ridge for 7 months and in construction/misc. for 5 months in 2000.										11
12	c. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										12
13								TOTAL	\$ 1,701		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 OF OLD TOWN WEST # 0042077 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number ( 773-286-3883  
 Fax Number ( 773-286-3743

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	see page 8a...				\$	\$		\$	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 ALDEN OF OLD TOWN WEST# 0042077

Report Period Beginning:

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12/31/00

## 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	WMF/HUNTOON		X	MORTGAGE	\$6,066.00	4/98	\$ 873,700	\$ 864,027	9/20/37	7.9700	\$ 69,002	1									
2												2									
3												3									
4												4									
5												5									
	<b>Working Capital</b>																				
6	CPT INTEREST	X		OPERATIONS	NONE					VARIES	16	6									
7	LINE OF CREDIT		X	OPERATIONS	NONE					VARIES	38,686	7									
8	RELATED PARTY		X	OPERATIONS	NONE					VARIES	508	8									
9	TOTAL Facility Related				\$6,066.00		\$ 873,700	\$ 864,027			\$ 108,212	9									
	<b>B. Non-Facility Related*</b>																				
10	Bloomington assoc interest		x	back out interest income							(252)	10									
11												11									
12												12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			(252)	14									
15	TOTALS (line 9+line14)						\$ 873,700	\$ 864,027			\$ 107,960	15									

\* 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 ALDEN OF OLD TOWN WEST

# 0042077 Report Period Beginning:

01/01/00 Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior BRICK VENEER Frame WOOD Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

none

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	DEV. DISABLED	18,000	1995	\$ 150,868	1
2					2
3	TOTALS	18,000		\$ 150,868	3

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XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1998		\$ 939,961	\$ 23,372	40	\$ 23,372	\$	\$ 59,049	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	dbs contracting-sprinkler system		1999		1,510	101	15	101		193	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	<b>TOTAL (lines 4 thru 35)</b>				\$ 941,471	\$ 23,472		\$ 23,472	\$	\$ 59,242	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.

Facility Name &amp; ID Number ALDEN OF OLD TOWN WEST

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## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	Related			1978	\$ 12,184	\$ 554	22	\$ 554		\$ 11,565	4	
5	Party			1978	5,953	271	32	271		4,767	5	
6	(Forum)										6	
7											7	
8											8	
	Improvement Type**											
9	Related Party - AMS:											
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10	
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11	
12											12	
13	Related Party - Forum:											
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14	
15	Leasehold Improvement - Remodeling			1980	113		10			113	15	
16	Leasehold Improvement - Remodeling			1986	32		6			32	16	
17	Leasehold Improvement - Remodeling			1990	51		5			51	17	
18	Leasehold Improvement - Remodeling			1991	12		5			12	18	
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19	
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20	
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21	
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22	
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23	
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24	
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25	
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26	
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)					\$ 58,177	\$ 3,514		\$ 3,514	\$	\$ 215,231	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.

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XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 135,160	\$ 14,887	\$ 14,887	\$	varies	\$ 27,455	37
38	Current Year Purchases	9,448	1,046	1,046		varies	1,046	38
39	Fully Depreciated Assets	20,651	1,214	1,214		varies	20,651	39
40								40
41	TOTALS	\$ 165,259	\$ 17,147	\$ 17,147	\$		\$ 49,152	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	\$ 26,682	\$ 2,494	\$ 2,494	\$	3	\$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			\$ 26,682	\$ 2,494	\$ 2,494	\$		\$ 3,030	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,342,457	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 46,628	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 46,628	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 326,655	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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: This section N/A, we own the building  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO  
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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

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.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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: \$ 2,620 Description: copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>related party-pg 8a...</u>	<u>various</u>	\$ <u>165.67</u>	\$ <u>1,988</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>165.67</u>	\$ <u>1,988</u>	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.

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. skilled nurses on-site...</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 AIDE _____</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 AIDE _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$			\$		1	
2	Licensed Speech and Language Development Therapist		hrs										2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist		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						(11)			(11)	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):	SEE PG 16A...							(931)			(931)	13	
14	<b>TOTAL</b>			\$		\$		\$	(942)		\$	(942)	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending:

12/31/00

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(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	\$ (5,329)	\$ (4,694)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 465 )	184,027	184,027	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,157	16,157	6
7	Other Prepaid Expenses		1,081	7
8	Accounts Receivable (owners or related parties)	2,531	5,116	8
9	Other(specify): <u>deferred taxes/escrows</u>	106,679	109,922	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 304,065	\$ 311,609	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		141,874	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	1,510	1,510	15
16	Equipment, at Historical Cost	19,294	77,403	16
17	Accumulated Depreciation (book methods)	(5,027)	(26,001)	17
18	Deferred Charges	10,149	10,149	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 25,925	\$ 1,139,797	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 329,991	\$ 1,451,406	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 83,684	\$ 97,279	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,819	5,819	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,409	22,409	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,203	8,203	31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,633	11,633	32
33	Accrued Interest Payable		5,739	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>third party</u>	237,743	329,304	36
37	<u>miscell accrued expenses/curr portion</u>	99	12,099	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 369,590	\$ 492,485	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		21,680	39
40	Mortgage Payable		852,027	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 873,707	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 369,590	\$ 1,366,192	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (39,598)	\$ 85,214	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 329,991	\$ 1,451,406	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (256,870)	1
2	Restatements (describe):		2
3	external audit adjustments done after 1999 cost report filed		3
4	which have no effect on reimbursable costs: bad debt expenses		4
5		(2,239)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (259,109)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	219,510	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 219,510</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (39,598)</b>	24 *

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

Facility Name &amp; ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

**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	\$ 1,065,619	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,065,619	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		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		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	expense adjustments for prior year activity	570	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 570	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,066,188	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	151,058	31
32	Health Care	314,466	32
33	General Administration	196,575	33
<b>B. Capital Expense</b>			
34	Ownership	151,260	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	449	35
36	Provider Participation Fee	32,870	36
<b>D. Other Expenses (specify):</b>			
37	does not balance to page 3 & 4 due to related party amounts		37
38	on page 3 & 4.		38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 846,678	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	219,510	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 219,510	43

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

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

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

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

Facility Name & ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending:

12/31/00

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			\$	\$	1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
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31					31
32					32
33					33
34					34
35	2,648	2,812	62,986	22.40	3
36	391	395	5,873	14.87	4
37	22,282	22,932	213,301	9.30	5
38					6
39	26	26	206	7.92	7
40					8
41					9
42					10
43					11
44	2,184	2,384	15,456	6.48	12
45					13
46	1,306	1,360	12,641	9.29	14
47	3,750	3,839	35,260	9.18	15
48					16
49					17
50					18
51					19
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A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
S. PASARELLI	administrator	0	\$ 11,471	Workers' Compensation Insurance	\$ 5,958	IDPH License Fee	\$ 0	
D. MOELLER	administrator	0	3,102	Unemployment Compensation Insurance	8,766	Advertising: Employee Recruitment	746	
				FICA Taxes	28,024	Health Care Worker Background Check	0	
				Employee Health Insurance	15,465	(Indicate # of checks performed _____)	0	
				Employee Meals	8,426			
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	912	
				DENTAL/LIFE INSUR.	834	OTHER MISC	344	
				employee relat/vaccin/misc p/r costs	1,713			
				401k match	49			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 14,573			related party-	56	
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	( )	
			\$			Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 73,491	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,058	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Alden Management Serv., Inc.	management fees		\$ 90,574			\$	Out-of-State Travel	\$
BLACKMAN KALLICK	ACCTG' FEES		3,800					
GATES/MCDONALD	unemployment comp.		163				In-State Travel	
US GAS & ENERGY	utility consult.		60				STATE FARM INSURANCE	53
ALDEN DESIGN	ARCHITECT/FEES		54					
ALDEN BENNET CONST.	CONSTRUCT.FEES		1,513				Seminar Expense	
							West's share of seminars	10
							related party-	1,450
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 96,164	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 1,513

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number ALDEN OF OLD TOWN WEST

# 0042077

Report Period Beginning: 01/01/00

Ending: 12/31/00

## 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. IHCA, \$912
- (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? na
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,612 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 of Public Aid during this cost report period. \$ 32,870  
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 of Public Aid, 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. \$ 8,426 Has any meal income been offset against related costs? NO Indicate the amount. \$ NA
- (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? NA
- d. Have vehicle usage logs been maintained? NA
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
- 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. \$ NA**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Blackman Kallick Bartelstein The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet completed
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? na  
Attach invoices and a summary of services for all architect and appraisal fees.