

		FOR OHF USE				

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

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>0044891</u></p> <p><b>Facility Name:</b> <u>Alden Alma Nelson Manor</u></p> <p><b>Address:</b> <u>550 S. Mulford</u> <u>Rockford</u> <u>61108</u>          Number City Zip Code</p> <p><b>County:</b> <u>Winnebago</u></p> <p><b>Telephone Number:</b> <u>(815) 484-1002</u> Fax # <u>(773) 286-3743</u></p> <p><b>IDPA ID Number:</b> <u>36-4367437</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>08/01/2000</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <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 type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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>  <b>Name:</b> <u>Steven M. Kroll</u> <b>Telephone Number:</b> <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 type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" 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>01/01/2002</u> to <u>12/31/2002</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"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Steven M. Kroll</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) (____) _____ 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>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Steven M. Kroll</u>	Paid Preparer	(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ 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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Facility Name & ID Number Alden Alma Nelson Manor

# 0044891 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

**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	268	Skilled (SNF)	268	97,820	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	268	TOTALS	268	97,820	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	4 Other		
8	SNF	15,118	3,711	15,683	34,512	8
9	SNF/PED					9
10	ICF	22,678	4,855	27	27,560	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,796	8,566	15,710	62,072	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.46%

D. How many bed-hold days during this year were paid by Public Aid? none (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 08/01/00

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/01/00 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 92 and days of care provided 15,649

Medicare Intermediary Administar Federal

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Alma Nelson Manor # 0044891 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

**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	355,617	28,567	6,000	390,184	3,437	393,621		393,621		1
2	Food Purchase		334,972		334,972	(30,141)	304,831	17,870	322,701		2
3	Housekeeping	261,697	47,411		309,108	1,229	310,337		310,337		3
4	Laundry	91,573	31,366		122,939	317	123,256		123,256		4
5	Heat and Other Utilities			194,315	194,315		194,315	(12,738)	181,577		5
6	Maintenance	77,529	1,506	170,628	249,663	1,919	251,582	9,283	260,865		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	786,416	443,822	370,943	1,601,181	(23,239)	1,577,942	14,415	1,592,357		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			33,000	33,000		33,000		33,000		9
10	Nursing and Medical Records	2,915,065	198,174	7,627	3,120,866	11,880	3,132,746	(45,873)	3,086,873		10
10a	Therapy	58,090			58,090		58,090		58,090		10a
11	Activities	78,447	965	1,792	81,204	73	81,277		81,277		11
12	Social Services	88,759			88,759		88,759		88,759		12
13	Nurse Aide Training										13
14	Program Transportation			35	35		35		35		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,140,361	199,139	42,454	3,381,954	11,953	3,393,907	(45,873)	3,348,034		16
	<b>C. General Administration</b>										
17	Administrative	166,646			166,646		166,646		166,646		17
18	Directors Fees										18
19	Professional Services			889,614	889,614		889,614	(845,065)	44,549		19
20	Dues, Fees, Subscriptions & Promotions			37,452	37,452	(2,377)	35,075	(20,653)	14,422		20
21	Clerical & General Office Expenses	609,226	20,589	52,976	682,791	2,382	685,173	88,541	773,714		21
22	Employee Benefits & Payroll Taxes			617,814	617,814	12,851	630,665	70,657	701,322		22
23	Inservice Training & Education										23
24	Travel and Seminar			35,679	35,679		35,679	13,565	49,244		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			57,141	57,141		57,141	12,146	69,287		26
27	Other (specify):* <b>bad debt</b>			175,970	175,970		175,970	(175,970)			27
28	<b>TOTAL General Administration</b>	775,872	20,589	1,866,646	2,663,107	12,856	2,675,963	(856,779)	1,819,184		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,702,649	663,550	2,280,043	7,646,242	1,570	7,647,812	(888,237)	6,759,575		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.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Alden Alma Nelson Manor

#0044891

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## 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					25,642	25,642	349,413	375,055			30
31	Amortization of Pre-Op. & Org.							1,839	1,839			31
32	Interest			72,040	72,040		72,040	478,177	550,217			32
33	Real Estate Taxes			182,242	182,242	(182,242)		187,757	187,757			33
34	Rent-Facility & Grounds			433,424	433,424	182,242	615,666	(614,952)	714			34
35	Rent-Equipment & Vehicles			18,308	18,308	285	18,593	20,183	38,776			35
36	Other (specify):* <b>Mortg. Insurance</b>			27,497	27,497	(27,497)						36
37	<b>TOTAL Ownership</b>			733,511	733,511	(1,570)	731,941	422,417	1,154,358			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		701,747	1,107,388	1,809,135		1,809,135	(326,159)	1,482,976			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		523		523		523	(523)	0			41
42	Provider Participation Fee			146,730	146,730		146,730		146,730			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		702,270	1,254,118	1,956,388		1,956,388	(326,682)	1,629,706			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,702,649	1,365,820	4,267,672	10,336,141		10,336,141	(792,503)	9,543,638			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 Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

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	(703)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,083)	2		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	(5,815)	32		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(175,970)	27		24
25	Fund Raising, Advertising and Promotional	(11,283)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (194,854)		\$	30

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)	(513,209)		34
35	Other- Attach Schedule	(84,440)	pg 5a	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (597,649)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (792,503)		37

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

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

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

Alden Alma Nelson Manor

ID# 0044891  
 Report Period Beginning: 01/01/2002  
 Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	BACK OUT: HEALTHCARE ASSOC PAC FEES	\$ (1,383)	20 1
2	BACK OUT:CLOTHING /GIFT SHOP ITEMS	(523)	41 2
3	LEGAL FEES-COLLECTIONS	(725)	21 3
4	BACK OUT MARKETING MGT FEE	(4,973)	20 4
5	BACK OUT MARKETING CONSULTANT	(3,470)	20 5
6	UTILITY LATE FEES	(16,623)	5 6
7	Record add'l def maint exp to correct amt.	(989)	6 7
8	Alma LLC - Int. to Related Party - AMS	(3,329)	32 8
9	Alma LLC - Int. to Related Party - Rockford Inv.	(50,133)	32 9
10	Adjust depreciation to correct amount on detail	3,469	30 10
11	back out Epic group costs in prof fees (marketing)	(5,760)	19 11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
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24			24
25			25
26			26
27			27
28			28
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(84,440)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891 Report Period Beginning:

01/01/2002 Ending: 12/31/2002

## 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	(1,083)	0	0	18,953	0	0	0	0	0	0	0	17,870	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	(16,623)	0	3,885	0	0	0	0	0	0	0	0	(12,738)	5
6	Maintenance	(989)	0	10,349	0	0	0	(77)	0	0	0	0	9,283	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(18,695)</b>	<b>0</b>	<b>14,234</b>	<b>18,953</b>	<b>0</b>	<b>0</b>	<b>(77)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>14,415</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	0	0	0	(43,587)	(2,286)	0	0	0	0	0	0	(45,873)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	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>0</b>	<b>0</b>	<b>0</b>	<b>(43,587)</b>	<b>(2,286)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(45,873)</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	(5,760)	0	(839,305)	0	0	0	0	0	0	0	0	(845,065)	19
20	Fees, Subscriptions & Promotions	(21,109)	0	456	0	0	0	0	0	0	0	0	(20,653)	20
21	Clerical & General Office Expenses	(725)	409	28,298	41,827	18,732	0	0	0	0	0	0	88,541	21
22	Employee Benefits & Payroll Taxes	0	0	67,676	0	2,981	0	0	0	0	0	0	70,657	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	13,565	0	0	0	0	0	0	0	0	13,565	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	12,146	0	0	0	0	0	0	0	0	0	12,146	26
27	Other (specify):*	(175,970)	0	0	0	0	0	0	0	0	0	0	(175,970)	27
28	<b>TOTAL General Administration</b>	<b>(203,564)</b>	<b>12,555</b>	<b>(729,310)</b>	<b>41,827</b>	<b>21,713</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(856,779)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(222,259)</b>	<b>12,555</b>	<b>(715,076)</b>	<b>17,193</b>	<b>19,427</b>	<b>0</b>	<b>(77)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(888,237)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

## 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	3,469	329,422	12,564	0	3,958	0	0	0	0	0	0	349,413 30
31	Amortization of Pre-Op. & Org.	0	0	1,698	0	0	141	0	0	0	0	0	1,839 31
32	Interest	(59,980)	480,118	52,966	0	3,120	1,953	0	0	0	0	0	478,177 32
33	Real Estate Taxes	0	182,242	4,548	0	967	0	0	0	0	0	0	187,757 33
34	Rent-Facility & Grounds	0	(615,666)	714	0	0	0	0	0	0	0	0	(614,952) 34
35	Rent-Equipment & Vehicles	0	0	20,183	0	0	0	0	0	0	0	0	20,183 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(56,511)</b>	<b>376,116</b>	<b>92,673</b>	<b>0</b>	<b>8,045</b>	<b>2,094</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>422,417 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	(57,531)	(123,023)	(145,605)	0	0	0	0	0	(326,159) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(523)	0	0	0	0	0	0	0	0	0	0	(523) 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>(523)</b>	<b>0</b>	<b>0</b>	<b>(57,531)</b>	<b>(123,023)</b>	<b>(145,605)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(326,682) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(279,294)</b>	<b>388,671</b>	<b>(622,403)</b>	<b>(40,338)</b>	<b>(95,551)</b>	<b>(143,511)</b>	<b>(77)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(792,503) 45</b>

Facility Name & ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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
see page 6k for others...				see page 6k for others		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 rental income	\$ 615,666	Alma Nelson Manor, LLC	0.00%	\$	(615,666) 1
2	V	21 miscell. G&A		Alma Nelson Manor, LLC		409	409 2
3	V	33 real estate taxes		Alma Nelson Manor, LLC			182,242 3
4	V	26 insurance		Alma Nelson Manor, LLC			12,146 4
5	V	32 interest on mortgage		Alma Nelson Manor, LLC			390,522 5
6	V	32 interest on other loans		Alma Nelson Manor, LLC			89,596 6
7	V	30 depreciation		Alma Nelson Manor, LLC			329,422 7
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 615,666			\$ 409	\$ * 388,671 14

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

Facility Name & ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	22	employee benefits	\$	Alden Management Services	\$ 67,676	\$ 67,676
16	V	19	profess. Fees	851,797	Alden Management Services	12,492	(839,305)
17	V	21	g & a		Alden Management Services	28,298	28,298
18	V	5	utilities		Alden Management Services	3,885	3,885
19	V	6	maintenance		Alden Management Services	10,349	10,349
20	V	24	auto/travel		Alden Management Services	13,565	13,565
21	V	20	subscriptions/etc		Alden Management Services	456	456
22	V	30	depreciation		Alden Management Services	12,564	12,564
23	V	31	amortization		Alden Management Services	1,698	1,698
24	V	33	real estate tax		Alden Management Services	4,548	4,548
25	V	34	rent		Alden Management Services	714	714
26	V	35	rent-equip/vehicles		Alden Management Services	20,183	20,183
27	V	32	interest		Alden Management Services	52,966	52,966
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 851,797			\$ 229,394	\$ * (622,403)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Tube feeding	\$ 7,843	Pyramid Health Care Services	100.00%	\$ 26,796	\$ 18,953
16	V	10 Nursing supplies	50,050	Pyramid Health Care Services		6,463	(43,587)
17	V	39 Per diem/other supplies	140,320	Pyramid Health Care Services		82,789	(57,531)
18	V	21 General & admin		Pyramid Health Care Services		41,827	41,827
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		\$ 198,213			\$ 157,875	\$ * (40,338)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39	Drugs	\$ 328,609	Forum Extended Care II	100.00%	\$ 251,923	\$ (76,686)	15
16	V	10	house stock	9,797	Forum Extended Care II		7,511	(2,286)	16
17	V	39	IV	198,561	Forum Extended Care II		152,224	(46,337)	17
18	V	22	Employee benefits		Forum Extended Care II		2,981	2,981	18
19	V	21	G & A		Forum Extended Care II		18,732	18,732	19
20	V	32	Interest		Forum Extended Care II		3,120	3,120	20
21	V	33	Real estate taxes		Forum Extended Care II		967	967	21
22	V	30	Depreciation		Forum Extended Care II		3,958	3,958	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		\$ 536,967			\$ 441,416	\$ *	(95,551)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy	\$ 1,096,053	Community Physical Therapy	100.00%	\$ 950,448	\$ (145,605)
16	V	32 Interest		Community Physical Therapy		1,953	1,953
17	V	31 Amortization		Community Physical Therapy		141	141
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		\$ 1,096,053			\$ 952,542	\$ * (143,511)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	6 maintenance expense	\$ 26,037	Alden Bennett Construction	100.00%	\$ 25,960	\$ (77)	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		\$ 26,037			\$ 25,960	\$ * (77)	39

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Alma Nelson Manor # 0044891 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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 a.	President	CEO		341,494	2.392	5.98	SALARY	\$ 21,718	17-1	1
2	Ami Pissetsky	Finance Coordinator	Banking	1.50	191,022	2.392	5.98	SALARY	12,149	17-1	2
3	Bob Molitor	C.O.O.	Operations	1.50	206,980	2.392	5.98	SALARY	13,164	17-1	3
4	Lauren Magnusson b.	Nurse coordinator	Nursing admin		86,228	2.392	5.98	SALARY	5,484	17-1	4
5	Terry Magnusson c.	Maint. Supervisor	construt/maint		80,685	2.392	5.98	SALARY	5,131	17-1	5
6	Steven Kroll	C.F.O.	Finance	1.50	213,513	2.392	5.98	SALARY	13,579	17-1	6
7	Joan Carl	Secretary	Vice-President		207,873	2.392	5.98	SALARY	13,220	17-1	7
8											8
9	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										9
10	b. Lauren is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator										10
11	c. Terry is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										11
12											12
13								TOTAL	\$ 84,445		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 Alma Nelson Manor # 0044891 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

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 Ave.  
 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 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	<a href="#">see page 8A (also on page 6A)</a>				\$	\$			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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Alden Alma Nelson Manor # 0044891 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## 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	National City Bank		X	Mortgage	Interest Only	8/1/00	\$ 8,120,000	\$ 8,120,000		Various	\$ 390,522	1								
2	Debes Corporation		X	Second Mortgage	None	8/1/00	819,589	254,201		6.4900	36,134	2								
3												3								
4												4								
5	National City Bank		X	Line of Credit	Interest Only	8/1/00		1,411,117		Various	66,226	5								
	<b>Working Capital</b>																			
6	Related party - AMS	X		Working capital							52,966	6								
7	Related party - FECII	X		Working capital							3,120	7								
8	Related party - CPT	X		Working capital							1,953	8								
9	TOTAL Facility Related						\$ 8,939,589	\$ 9,785,318			\$ 550,920	9								
	<b>B. Non-Facility Related*</b>																			
10	offset interest expense on Corp with interest income											(703)	10							
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (703)	14								
15	TOTALS (line 9+line14)						\$ 8,939,589	\$ 9,785,318			\$ 550,217	15								

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

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

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

Facility Name & ID Number **Alden Alma Nelson Manor**# **0044891** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2001 report.		\$	174,354	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.)		\$	174,354	2
3.	Under or (over) accrual (line 2 minus line 1).		\$		3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	182,242	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	182,242	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997		8	
		1998		9	
		1999		10	
		2000	171,256	11	
		2001	174,354	12	
<b>Accrual based on 4% increase over prior year bill.</b>					
				<b>FOR OHF USE ONLY</b>	
		13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden Alma Nelson Manor COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0044891

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

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

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-27-152-003</u>	<u>Nursing home facility</u>	\$ <u>5,996.24</u>	\$ <u>5,996.24</u>
2. <u>12-27-152-002</u>	<u>Nursing home facility</u>	\$ <u>84,405.86</u>	\$ <u>84,405.86</u>
3. <u>12-27-152-001</u>	<u>Nursing home facility</u>	\$ <u>83,951.60</u>	\$ <u>83,951.60</u>
4. _____	<u>Related Party - Alden Management</u>	\$ <u>76,052.00</u>	\$ <u>4,548.00</u>
5. _____	<u>Related Party - Forum</u>	\$ <u>8,608.00</u>	\$ <u>967.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>259,013.70</u>	\$ <u>179,868.70</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891 Report Period Beginning:

01/01/2002 Ending:

12/31/2002

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. 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).

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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	Nursing home			\$ 700,000	1
2					2
3	TOTALS			\$ 700,000	3

Facility Name & ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

**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 party-Forum		1978	\$ 18,359	\$	22	\$	\$	\$
5									
6	268			7,000,000	222,222		222,222		537,037
7									
8									
<b>Improvement Type**</b>									
9	GT Mechanical - replace 75 ton compressor		2000	23,550	2,355	10	2,355		5,495
10	Alden Bennett Const.		2001	16,737	1,674	10	1,674		3,208
11	Pro com systems		2001	4,055	406	10	406		777
12	Alden Bennett Const.		2001	2,098	210	10	210		367
13	New Horz. Comm		2001	1,701	170	10	170		284
14	Alden Bennett Const.		2001	1,816	182	10	182		303
15	Alden Bennett Const.		2001	2,263	226	10	226		358
16	Alden Bennett Const.		2001	2,828	283	10	283		424
17	Seams -rebuild engine		2001	4,938	494	10	494		700
18	Alden Bennett Const.		2001	1,632	163	10	163		231
19	CSI Coker - belt/heating element		2001	5,256	526	10	526		613
20	Alden Bennett Const.		2001	3,198	320	10	320		373
21	GT Mechanical - heater		2001	2,406	241	10	241		261
22	GT Mechanical, Inc. - Repair Air Conditioner		2002	11,519	576	10	576		576
23	Pro Com Systems - Repair Nurse Call System		2002	1,862	124	10	124		124
24	GT Mechanical, Inc. - Repair Heater		2002	1,996	183	10	183		183
25	FE Moran - Repair - Fire Alarm System		2002	1,825	76	10	76		76
26	Nelson Carlson - Repair Water Main		2002	2,407	221	10	221		221
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Building Improvements		\$	\$		\$	\$	\$		37
38	Alden Design - HVAC	2000	5,142	257	20	257		578		38
39	Alden Design - elect./plumbing	2000	3,089	154	20	154		347		39
40	Alden Design - misc	2001	22,472	1,124	20	1,124		2,247		40
41	Alden Design - misc	2001	22,412	1,121	20	1,121		2,241		41
42	ABC - laundry room repairs	2001	94,243	4,712	20	4,712		9,032		42
43	ABC - laundry room repairs	2001	11,608	580	20	580		919		43
44	ABC - laundry room repairs	2001	9,602	40	20	40		40		44
45	ABC - laundry room repairs	2002	(9,602)	(40)	20	(40)		(40)		45
46	ABC - Carpet	2002	1,231	27	20	27		27		46
47	ABC - Chimney	2002	3,032	38	20	38		38		47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 7,273,674	\$ 238,664		\$ 238,664	\$	\$ 567,041		70

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

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

## 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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 7,273,674	\$ 238,664		\$ 238,664		\$ 567,041		1
2	Related Party-Forum:								2
3	Leasehold Improvement-Remodeling	1980	19,335		20		19,334		3
4	Leasehold Improvement-Remodeling	1980	1,208		10		1,208		4
5	Leasehold Improvement-Remodeling	1986	645		5		645		5
6	Leasehold Improvement-Remodeling	1990	404		5		404		6
7	Leasehold Improvement-Remodeling	1991	94		5		94		7
8	Leasehold Improvement-Remodeling	1993	8,304	830	10	830	8,304		8
9	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469	6,504		9
10	Leasehold Improvement-sign	1994	261	22	12	22	174		10
11	Leasehold Improvement-dryvit	1995	443	44	10	44	310		11
12	Leasehold Improvement-new ac	1999	723	48	15	48	145		12
13	Leasehold Improvement-roof	1985	972	52	19	52	922		13
14	Leasehold Improvement-roof	1994	863	58	15	58	518		14
15	Leasehold Improvement-roof	1997	819	55	15	55	328		15
16	Leasehold Improvement-roof	1998	1,390	93	15	93	464		16
17	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11	33		17
18	Leasehold Improvement-hallway lighting	2001	155	16	10	16	32		18
19	Leasehold Improvement-DAI	2001	195	19	10	19	38		19
20	Leasehold Improvement-bathrooms	2002	687	69	10	69	69		20
21	Leasehold Improvement-Remodeling	2002	98	20	5	20	20		21
22	Related Party-AMS:								22
23	Leasehold Improvement-Remodeling	1993	4,266		7		4,266		23
24	Leasehold Improvement-Remodeling	1994	2,112		7		2,112		24
25	Leasehold Improvement-Remodeling	2002	5,221		7				25
26									26
27									27
28									28
29									29
30									30
31	Related Party-Forum Ext. Care	1999	1,764	712	40	712	183		31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 7,330,248	\$ 241,182		\$ 241,182		\$ 613,148		34

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

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	
71	Purchased in Prior Years	\$ 667,889	\$ 125,710	\$ 125,710	\$	VARIOUS	\$ 308,642	71
72	Current Year Purchases	51,428	3,480	3,480		VARIOUS	3,480	72
73	Fully Depreciated Assets	39,228	891	891		VARIOUS	39,228	73
74								74
75	TOTALS	\$ 758,544	\$ 130,081	\$ 130,081	\$		\$ 351,350	75

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	
76	CAR ENGINE/BUS/VAN	:DODGE	98-02	\$ 12,336	\$ 3,792	\$ 3,792	\$	3	\$ 9,992	76
77										77
78										78
79										79
80	TOTALS			\$ 12,336	\$ 3,792	\$ 3,792	\$		\$ 9,992	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)	\$ 8,801,129	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 375,055	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 375,055	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 974,490	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		\$ n/a	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: related party- cost is backed out.

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 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.                   /2003      \$ \_\_\_\_\_

13.                   /2004      \$ \_\_\_\_\_

14.                   /2005      \$ \_\_\_\_\_

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: \$ 18,593      Description: copy machine lease \$18,308, postage meter \$285

(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>non-patient transport.</u>		\$ <u>10.57</u>	\$ <u>127</u>	17
18	<u>Various</u>	<u>various</u>	<u>1,681.92</u>	<u>20,183</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>1,692.48</u>	\$ <u>20,310</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.

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

**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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled nurses on site</u></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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 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>	

- (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.

- (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	39-3	hrs	\$		\$	405,386	\$		\$	405,386		1	
2	Licensed Speech and Language Development Therapist	39-3	hrs				70,324				70,324		2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-3	hrs				608,407				608,407		4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	see page 16a	# of prescripts							190,987			190,987	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 page 16a								207,872			207,872	13
14	TOTAL			\$		\$	1,084,117	\$	398,859	\$	1,482,976		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 Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance <u>190,000</u> )	2,114,523	2,114,523	3
4 Supply Inventory (priced at <u>848</u> )	848	848	4
5 Short-Term Investments			5
6 Prepaid Insurance	7,693	7,693	6
7 Other Prepaid Expenses		5,779	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <u>Due from IDPA</u>	29,204	29,204	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,152,268	\$ 2,158,047	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments		1,436,265	12
13 Land		700,000	13
14 Buildings, at Historical Cost	163,228	7,163,228	14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	229,382	765,382	16
17 Accumulated Depreciation (book methods)	(56,702)	(852,806)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 335,908	\$ 9,212,069	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,488,176	\$ 11,370,116	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 538,502	\$ 538,502	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	155,389	155,389	28
29 Short-Term Notes Payable	1,411,117	1,411,117	29
30 Accrued Salaries Payable	276,319	276,319	30
31 Accrued Taxes Payable (excluding real estate taxes)	27,297	27,297	31
32 Accrued Real Estate Taxes(Sch.IX-B)		182,242	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <u>Due from Blue Cross Blue Shield</u>	74,408	74,408	36
37 <u>Due to affiliates &amp; other accr expns</u>	113,138	1,310,944	37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,596,170	\$ 3,976,218	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable		8,374,201	39
40 Mortgage Payable			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>	\$	\$ 8,374,201	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,596,170	\$ 12,350,419	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ (107,995)	\$ (980,304)	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,488,176	\$ 11,370,116	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (355,822)	1
2	Restatements (describe):		2
3	External auditor adjustments made after 2001 cost report		3
4	was filed . These adjustments have no effect on	18,893	4
5	reimbursable costs (bad debt exp / medicare revenue ).		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (336,929)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	228,934	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>\$ 228,934</b>	<b>17</b>
<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>	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (107,995)</b>	<b>24 *</b>

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

Facility Name & ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

**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	\$ 9,916,202	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,916,202	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	101,482	5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 101,482	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	2,222	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>	\$ 2,222	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,530	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,530	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Misc. other income</u>	1,173	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,173	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,023,608	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,601,181	31
32	Health Care	3,381,954	32
33	General Administration	2,663,107	33
<b>B. Capital Expense</b>			
34	Ownership	733,511	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,809,658	35
36	Provider Participation Fee	146,730	36
<b>D. Other Expenses (specify):</b>			
37	<u>Related party salary allocations</u>	(541,467)	37
38	<u>party information input to these pages.</u>		38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,794,674	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	228,934	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 228,934	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 &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,915	2,083	\$ 73,074	\$ 35.08	1
2	Assistant Director of Nursing	692	724	21,960	30.33	2
3	Registered Nurses	16,913	17,914	472,757	26.39	3
4	Licensed Practical Nurses	47,270	49,221	988,337	20.08	4
5	Nurse Aides & Orderlies	107,006	110,397	1,251,308	11.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,427	1,451	17,751	12.23	9
10	Activity Assistants	6,127	6,593	60,696	9.21	10
11	Social Service Workers	4,088	4,280	67,770	15.83	11
12	Dietician					12
13	Food Service Supervisor	4,813	4,944	107,161	21.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,282	30,547	248,456	8.13	15
16	Dishwashers					16
17	Maintenance Workers	1,832	1,920	57,034	29.71	17
18	Housekeepers	31,868	33,129	261,697	7.90	18
19	Laundry	8,188	8,752	91,573	10.46	19
20	Administrator	624	640	9,938	15.53	20
21	Assistant Administrator					21
22	Other Administrative	10,531	11,322	203,770	18.00	22
23	Office Manager	1,638	1,899	20,989	11.05	23
24	Clerical	9,546	10,213	79,749	7.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,588	3,867	94,266	24.38	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,832	2,016	23,452	11.63	31
32	Other Health C: Clinical SS	316	332	9,445	28.45	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	289,496	302,244	\$ 4,161,183 *	\$ 13.77	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 6,000	1-3	35
36	Medical Director	Monthly	33,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,432	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,290	11-3	44
45	Social Service Consultant	8	432	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	32	\$ 47,154		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Klekamp, S	Administrator	0	50,328	Workers' Compensation Insurance	79,351	IDPH License Fee		
Taylor, G	Administrator	0	15,000	Unemployment Compensation Insurance	52,356	Advertising: Employee Recruitment		
Executive/Management	Administrator	0	101,312	FICA Taxes	311,765	Health Care Worker Background Check		
				Employee Health Insurance	76,572	(Indicate # of checks performed _____)		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Meals	30,141	Surety Bond Fees, Dues & Subscriptions	2,462	
(List each licensed administrator separately.)			\$ 166,640	Illinois Municipal Retirement Fund (IMRF)*		II. Health Care Assoc.	11,504	
				Related party - FECH	2,981			
				Union Health & Welfare	29,839			
				Dental, Life, Relations & Misc.	16,530			
				Background Cks., Tuition & Drug Test	5,224	Related Party - AMS	456	
				401k Match, Vaccinations, Other	28,887	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
				Related Party - AMS	67,676	Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 701,322	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,422	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other				Description	Line #	Amount	Description	Amount
Description			Amount					
			\$				Out-of-State Travel	\$
							In-State Travel	
							Misc., Gas, Auto Repairs	10,111
							lodging/meals for non-resident staff	25,118
							Related Party - AMS	13,565
							Seminar Expense	
							O.C.C.	450
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 49,244
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type	Amount						
AMS	Management Fees	851,797						
BDO Siedman	Accounting Fees	4,369						
Ken Fisch / Greenberg	Legal Fees	18,036						
The Epic Group	Consultants	5,760						
Century Personnel	Placement Service	3,333						
Achieve Accreditation / Other	Consulting Services	2,880						
Medi.Com	Billing Consultants	448						
Talx	Workers Comp Consulting	524						
U S Gas & Energy Corp	Utilities	2,466						
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 889,614					

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	GT Mechanical - A/C	\$ 2,021	5	\$	\$	\$ 236	\$ 404	\$ 404	\$ 404	\$ 404	\$ 169	\$ 0
2	GT Mechanical - Chiller	1,988	5			199	397	397	397	397	201	0
3	CSI Corker - dishwasher	3,404	5			57	681	681	681	681	623	0
4	no 2002 additions											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$ 7,413		\$	\$	\$ 492	\$ 1,482	\$ 1,482	\$ 1,482	\$ 1,482	\$ 993	\$

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. IL Healthcare Assoc. \$11,504
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,823 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. \$ 146,730  
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? yes 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. \$ 30,141 Has any meal income been offset against related costs? no Indicate the amount. \$ 0
- (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? n/a  
d. Have vehicle usage logs been maintained? n/a  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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? yes  
Attach invoices and a summary of services for all architect and appraisal fees.