

		FOR OHF USE				

LL 1

**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>0036640</u></p> <p><b>Facility Name:</b> <u>Alden Valley Ridge Rehab &amp; HCC</u></p> <p><b>Address:</b> <u>275 E. Army Trail Rd.</u> <u>Bloomington</u> <u>60108</u>          Number City Zip Code</p> <p><b>County:</b> <u>DuPage</u></p> <p><b>Telephone Number:</b> <u>(630) 893-9616</u> Fax # <u>(630) 924-1059</u></p> <p><b>IDPA ID Number:</b> <u>36-3738956</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/91</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																											
<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 _____																												
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 # (____) _____																												

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

# 0036640 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	<u>207</u>	Skilled (SNF)		<u>75,555</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>207</u>	TOTALS		<u>75,555</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF	<u>22,480</u>	<u>4,485</u>	<u>8,365</u>	<u>35,330</u>	8
9	SNF/PED					9
10	ICF	<u>21,540</u>	<u>1,832</u>	<u>647</u>	<u>24,019</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,020</u>	<u>6,317</u>	<u>9,012</u>	<u>59,349</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.55%

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 02/01/91

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/01/91 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 61 and days of care provided 6,782

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 Valley Ridge Rehab & HCC # 0036640 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	317,143	34,381	(2,961)	348,563	1,310	349,873		349,873		1
2	Food Purchase		380,033		380,033	(35,086)	344,947	(7,273)	337,674		2
3	Housekeeping	168,866	33,896		202,762	939	203,701		203,701		3
4	Laundry	51,405	14,890		66,295		66,295		66,295		4
5	Heat and Other Utilities			218,360	218,360		218,360	(2,685)	215,675		5
6	Maintenance	51,240	4,763	149,324	205,327	4,265	209,592	15,174	224,766		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	588,654	467,963	364,723	1,421,340	(28,572)	1,392,768	5,217	1,397,985		8
<b>B. Health Care and Programs</b>											
9	Medical Director			19,500	19,500		19,500		19,500		9
10	Nursing and Medical Records	2,420,290	183,273	4,968	2,608,531	3,020	2,611,551	(6,219)	2,605,332		10
10a	Therapy	81,190			81,190		81,190		81,190		10a
11	Activities	58,069	3,548	12,387	74,004	1,102	75,106		75,106		11
12	Social Services	46,225			46,225		46,225		46,225		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,605,774	186,821	36,855	2,829,450	4,122	2,833,572	(6,219)	2,827,353		16
<b>C. General Administration</b>											
17	Administrative	166,423			166,423		166,423		166,423		17
18	Directors Fees										18
19	Professional Services			804,064	804,064	(1,080)	802,984	(747,962)	55,022		19
20	Dues, Fees, Subscriptions & Promotions			72,260	72,260		72,260	(57,975)	14,285		20
21	Clerical & General Office Expenses	492,742	17,322	36,447	546,511	162	546,673	46,158	592,831		21
22	Employee Benefits & Payroll Taxes			467,573	467,573	29,633	497,206	67,882	565,088		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,622	8,622		8,622	12,995	21,617		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,735	47,735		47,735	10,067	57,802		26
27	Other (specify):* <b>Bad debt</b>			162,550	162,550		162,550	(162,550)			27
28	<b>TOTAL General Administration</b>	659,165	17,322	1,599,251	2,275,738	28,715	2,304,453	(831,385)	1,473,068		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,853,593	672,106	2,000,829	6,526,528	4,265	6,530,793	(832,387)	5,698,406		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

Facility Name & ID Number Alden Valley Ridge Rehab & HCC #0036640 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					74,091	74,091	257,809	331,900		30
31	Amortization of Pre-Op. & Org.							637,073	637,073		31
32	Interest			78,999	78,999		78,999	996,569	1,075,568		32
33	Real Estate Taxes			187,200	187,200	(187,200)		154,089	154,089		33
34	Rent-Facility & Grounds			833,395	833,395	187,200	1,020,595	(1,019,911)	684		34
35	Rent-Equipment & Vehicles			8,927	8,927		8,927	19,334	28,261		35
36	Other (specify):* <b>Mortg. Insurance</b>			78,356	78,356	(78,356)		6,297	6,297		36
37	<b>TOTAL Ownership</b>			1,186,877	1,186,877	(4,265)	1,182,612	1,051,260	2,233,872		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		362,867	528,365	891,232		891,232	(333,711)	557,521		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops		89		89		89	(89)	(0)		41
42	Provider Participation Fee			113,333	113,333		113,333		113,333		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		362,956	641,698	1,004,654		1,004,654	(333,800)	670,854		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,853,593	1,035,062	3,829,404	8,718,059		8,718,059	(114,928)	8,603,131		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 Valley Ridge Rehab & HCC

# 0036640

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	(49,252)	30		9
10	Interest and Other Investment Income	1,049	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,359)	2		13
14	Non-Care Related Interest	(43,760)	32		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	926	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	(162,550)	27		24
25	Fund Raising, Advertising and Promotional	(40,409)	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>	\$ (295,405)		\$	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)	221,970		34
35	Other- Attach Schedule	(41,493)	pg 5a	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 180,477		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (114,928)		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 Valley Ridge Rehab & HCC

ID# 0036640  
 Report Period Beginning: 01/01/2002  
 Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	LEGAL FEES-COLLECTIONS	(5,525)	21	1
2	BACK OUT IL. HEALTHCARE ASSOC PAC FEES	(985)	20	2
3	BACK OUT MARKETING MGT FEE	(14,115)	20	3
4	BACK OUT MARKETING CONSULTANT	(2,852)	20	4
5	BACK OUT CLOTHING GIFT SHOP	(89)	41	5
6	Record add'l def maint exp to correct amt.	5,278	6	6
7	Back out utility late fee	(6,407)	5	7
8	Adj deprec exp to correct actual amount	(1,189)	30	8
9	Back out interest expense for late fees	(2,515)	32	9
10	back out related party interest in gl 7031/7053	(9,624)	32	10
11	back out recovery on tax penalty in gl 6970	8,896	32	11
12	back out Epic group marketing costs from prof fees	(4,000)	19	12
13	back out salary for marketing	(8,366)	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(41,493)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Valley Ridge Rehab &amp; HCC

# 0036640

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	(1,359)	0	0	(5,914)	0	0	0	0	0	0	0	(7,273)	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	(6,407)	0	3,722	0	0	0	0	0	0	0	0	(2,685)	5
6	Maintenance	5,278	0	9,913	0	0	0	(17)	0	0	0	0	15,174	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,487)</b>	<b>0</b>	<b>13,635</b>	<b>(5,914)</b>	<b>0</b>	<b>0</b>	<b>(17)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,217</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	(5,396)	(823)	0	0	0	0	0	0	(6,219)	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>(5,396)</b>	<b>(823)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,219)</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	(4,000)	5,380	(749,342)	0	0	0	0	0	0	0	0	(747,962)	19
20	Fees, Subscriptions & Promotions	(58,411)	0	436	0	0	0	0	0	0	0	0	(57,975)	20
21	Clerical & General Office Expenses	(13,891)	0	27,108	24,062	8,879	0	0	0	0	0	0	46,158	21
22	Employee Benefits & Payroll Taxes	0	0	66,469	0	1,413	0	0	0	0	0	0	67,882	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	12,995	0	0	0	0	0	0	0	0	12,995	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	10,067	0	0	0	0	0	0	0	0	0	10,067	26
27	Other (specify):*	(162,550)	0	0	0	0	0	0	0	0	0	0	(162,550)	27
28	<b>TOTAL General Administration</b>	<b>(238,852)</b>	<b>15,447</b>	<b>(642,334)</b>	<b>24,062</b>	<b>10,292</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(831,385)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(241,339)</b>	<b>15,447</b>	<b>(628,699)</b>	<b>12,752</b>	<b>9,469</b>	<b>0</b>	<b>(17)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(832,387)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Valley Ridge Rehab &amp; HCC

# 0036640

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	(50,441)	293,810	12,564	0	1,876	0	0	0	0	0	0	257,809 30
31	Amortization of Pre-Op. & Org.	0	635,382	1,626	0	0	65	0	0	0	0	0	637,073 31
32	Interest	(45,028)	988,474	50,739	0	1,479	905	0	0	0	0	0	996,569 32
33	Real Estate Taxes	0	149,275	4,356	0	458	0	0	0	0	0	0	154,089 33
34	Rent-Facility & Grounds	0	(1,020,595)	684	0	0	0	0	0	0	0	0	(1,019,911) 34
35	Rent-Equipment & Vehicles	0	0	19,334	0	0	0	0	0	0	0	0	19,334 35
36	Other (specify):*	0	6,297	0	0	0	0	0	0	0	0	0	6,297 36
37	<b>TOTAL Ownership</b>	<b>(95,469)</b>	<b>1,052,643</b>	<b>89,303</b>	<b>0</b>	<b>3,813</b>	<b>970</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,051,260 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	(26,634)	(58,577)	(248,500)	0	0	0	0	0	(333,711) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(89)	0	0	0	0	0	0	0	0	0	0	(89) 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>(89)</b>	<b>0</b>	<b>0</b>	<b>(26,634)</b>	<b>(58,577)</b>	<b>(248,500)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(333,800) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(336,898)</b>	<b>1,068,090</b>	<b>(539,396)</b>	<b>(13,882)</b>	<b>(45,295)</b>	<b>(247,530)</b>	<b>(17)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(114,928) 45</b>

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.	100	See page 6k		See page 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:
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 Rent income	\$ 1,020,595	Valley Ridge Associates Limited Partnership	100.00%	\$	\$ (1,020,595)
2	V	32 Investment income - RR	1,233	Valley Ridge Associates Limited Partnership			(1,233)
3	V	36 Easment award	22,340	Valley Ridge Associates Limited Partnership			(22,340)
4	V	36 Gain on sale of land	28,970	Valley Ridge Associates Limited Partnership			(28,970)
5	V	19 Audit expense		Valley Ridge Associates Limited Partnership		3,700	3,700
6	V	19 Bank charges and misc. exp		Valley Ridge Associates Limited Partnership		1,680	1,680
7	V	31 Amortization		Valley Ridge Associates Limited Partnership		635,382	635,382
8	V	33 Real estate taxes		Valley Ridge Associates Limited Partnership		149,275	149,275
9	V	26 Property & liability insurance		Valley Ridge Associates Limited Partnership		10,067	10,067
10	V	32 Interest on mortgage payable		Valley Ridge Associates Limited Partnership		643,792	643,792
11	V	36 Mortgage insurance premium		Valley Ridge Associates Limited Partnership		57,607	57,607
12	V	32 Prepayment penalty on debt		Valley Ridge Associates Limited Partnership		345,915	345,915
13	V	30 Depreciation		Valley Ridge Associates Limited Partnership		293,810	293,810
14	Total		\$ 1,073,138			\$ 2,141,228	\$ * 1,068,090

\* 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	22	Employee Benefits	\$		\$ 66,469	\$ 66,469
16	V	19	Management fees	761,308	Alden Management Services, Inc.	11,966	(749,342)
17	V	21	Gen'l & Admin.		Alden Management Services, Inc.	27,108	27,108
18	V	5	utilities		Alden Management Services, Inc.	3,722	3,722
19	V	6	maintenance/utilities		Alden Management Services, Inc.	9,913	9,913
20	V	24	autos/seminars		Alden Management Services, Inc.	12,995	12,995
21	V	20	dues/subscriptions		Alden Management Services, Inc.	436	436
22	V	30	depreciation		Alden Management Services, Inc.	12,564	12,564
23	V	31	amortization		Alden Management Services, Inc.	1,626	1,626
24	V	33	real estate tax		Alden Management Services, Inc.	4,356	4,356
25	V	34	rent		Alden Management Services, Inc.	684	684
26	V	35	rent-equip/vehicles		Alden Management Services, Inc.	19,334	19,334
27	V	32	interest		Alden Management Services, Inc.	50,739	50,739
28	V	19	Marketing Fees		Alden Management Services, Inc.		
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 761,308			\$ 221,912	\$ * (539,396)

\* 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	\$ 30,695	Pyramid Health Care Services	100.00%	\$ 24,781	\$ (5,914)
16	V	10 Nursing supply	18,373	Pyramid Health Care Services		12,977	(5,396)
17	V	39 Per diem/other supply	64,960	Pyramid Health Care Services		38,326	(26,634)
18	V	21 General & admin		Pyramid Health Care Services		24,062	24,062
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		\$ 114,028			\$ 100,146	\$ * (13,882)

\* 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	\$ 135,531	Forum Extended Care II	100.00%	\$ 103,903	\$ (31,628)
16	V	10 House stock	3,526	Forum Extended Care II		2,703	(823)
17	V	39 IV	115,481	Forum Extended Care II		88,532	(26,949)
18	V	22 Employee benefits		Forum Extended Care II		1,413	1,413
19	V	21 G & A		Forum Extended Care II		8,879	8,879
20	V	32 Interest		Forum Extended Care II		1,479	1,479
21	V	33 Real estate taxes		Forum Extended Care II		458	458
22	V	30 Depreciation		Forum Extended Care II		1,876	1,876
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		\$ 254,538			\$ 209,243	\$ * (45,295)

\* 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	\$ 507,998	Community Physical Therapy	100.00%	\$ 259,498	\$ (248,500)
16	V	32 Interest		Community Physical Therapy		905	905
17	V	31 Amortization		Community Physical Therapy		65	65
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		\$ 507,998			\$ 260,468	\$ * (247,530)

\* 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	\$ 5,719	Alden Bennett Construction	100.00%	\$ 5,702	\$ (17)
16	V						
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		\$ 5,719			\$ 5,702	\$ * (17)

\* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	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		\$			\$	0 \$ *	39

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

Facility Name & ID Number Alden Valley Ridge Rehab & HCC # 0036640 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 A Schlossberg	President		34.00	342,407	2.292	5.73	SALARY	\$ 20,805	17-1	1
2	Lauren Magnusson	Clinical Coord		A	86,459	2.292	5.73	SALARY	5,253	17-1	2
3	Terry Magnusson	Maint Super.		A	80,900	2.292	5.73	SALARY	4,916	17-1	3
4	Joan Carl	Vice president-AMS.		15.00	208,424	2.292	5.73	SALARY	12,664	17-1	4
5											5
6											6
7											7
8											8
9											9
10	A. Relatives of Floyd A Schlossberg										10
11											11
12											12
13								TOTAL	\$ 43,638		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 Valley Ridge Rehab & HCC # 0036640 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 Valley Ridge Rehab & HCC # 0036640 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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Cambridge Realty Capital		X	Mortgage	\$50,767.00	11/02	\$ 9,009,300	\$ 8,996,327	8/31/37	5.9000	\$ 643,792	1
2	Corus		x	working capital	\$19,028.00		900,000	304,440	5/04		28,929	2
3												3
4	interest on prepayment of loan		x	mortgage							345,915	4
5	interest expense on bus loan		x	operations							3,993	5
	<b>Working Capital</b>											
6	Related party - AMS	X		Working capital							52,628	6
7	Related party - FECII	X		Working capital							1,479	7
8	Related party - CPT	X		Working capital							905	8
9	TOTAL Facility Related				\$69,795.00		\$ 9,909,300	\$ 9,300,767			\$ 1,077,641	9
	<b>B. Non-Facility Related*</b>											
10	offset interest expense with VR Assoc interest income										(1,233)	10
11	offset interest expense with Corps interest income										(840)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (2,073)	14
15	TOTALS (line 9+line14)						\$ 9,909,300	\$ 9,300,767			\$ 1,075,568	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 57,607 Line # 36

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

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



**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 Valley Ridge Rehab & HCC COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0036640

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>02-23-031-017</u>	<u>Nursing home facility</u>	\$ <u>2,515.70</u>	\$ <u>2,515.70</u>
2. <u>02-23-301-009</u>	<u>Nursing home facility</u>	\$ <u>141,459.70</u>	\$ <u>141,459.70</u>
3. _____	<u>Related Party - Alden Management</u>	\$ <u>76,052.00</u>	\$ <u>4,356.00</u>
4. _____	<u>Related Party - Forum</u>	\$ <u>8,608.00</u>	\$ <u>458.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>228,635.40</u>	\$ <u>148,789.40</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 Valley Ridge Rehab &amp; HCC

# 0036640 Report Period Beginning:

01/01/2002 Ending:

12/31/2002

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,046 B. General Construction Type: Exterior brick Frame steel Number of Stories 3C. 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).

---



---



---



---



---



---

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: 759,322 2. Number of Years Over Which it is Being Amortized: 5 years / 40 years  
3. Current Period Amortization: 21,414 4. Dates Incurred: 1990-1991

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		1990	\$ 317,223	1
2					2
3	TOTALS			\$ 317,223	3

Facility Name & ID Number Alden Valley Ridge Rehab & HCC

# 0036640

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	\$	\$	\$ 18,359
5	207	1991		6,027,235	250,160	30	200,908	(49,252)	2,394,153
6									
7									
8									
	<b>Improvement Type**</b>								
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
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 &amp; ID Number Alden Valley Ridge Rehab &amp; HCC

# 0036640

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	LEASEHOLD IMPROVEMENTS	1991	\$ 1,644,299	\$	VARIOUS	\$	\$	\$ 747,760		37
38	REPAIR A/C,CONTROL SYSTEM & PUMP/MISC.	1991	18,611		5			18,611		38
39	EXHAUST FAN/HVAC/BURNISHER/MISC.	1992	32,815	1,639	5,10 & 15	1,639		26,925		39
40	PIPE INSULATION/HVAC/MISC.	1993	31,308	1,935	5,10,15 & 17	1,935		24,036		40
41	SEWER WORK/CARPETING/ROOFING/INJECTOR PUMP	1994	28,814	1,129	5,10 & 25	1,129		22,795		41
42	REPAIR PUMPS/FAUCETS/HVAC/REGROUT SHOWERS/MSC	1995	28,634	2,272	10,15 & 20	2,272		17,721		42
43	ROOF REPAIR	1996	3,200	320	10	320		2,133		43
44	ROOF REPAIR	1996	2,500	250	10	250		1,604		44
45	PARKING LOT LIGHTING	1996	3,716	248	15	248		1,590		45
46	PARKING LOT LIGHTING,EMRGNCY SERVICE-POWER OUT	1997	8,767		5			8,767		46
47	REPAIR PUMP	1997	1,800	120	5	120		1,800		47
48	ROOF REPAIRS	1997	2,590	216	5	216		2,590		48
49	REPLACE COMPRESSOR	1997	6,885	689	5	689		6,885		49
50	REPLACE MIXING VALVE	1997	2,763	332	5	332		2,763		50
51	REPAIR PUMP	1997	2,161	144	5	144		2,160		51
52	REPLACE PUMP	1997	6,293	420	5	420		6,293		52
53	REPLACED COMPRESSOR	1997	5,000	319	5	319		5,000		53
54	ROOF REPAIRS	1997	1,800	300	5	300		1,800		54
55	DOOR HOLDER	1997	4,088	409	10	409		2,078		55
56	PARKING LOT	1997	131,918	6,596	20	6,596		99,462		56
57	INSTALL WALL PLATES/OUTLETS	1997	4,968	497	10	497		2,608		57
58	INSTALL CABLE	1998	5,244	524	10	524		2,316		58
59	PAINTING	1998	52,000	2,600	20	2,600		11,483		59
60	CARPETING	1998	59,500	2,975	20	2,975		13,140		60
61	DRAPERIES	1998	13,000	650	20	650		2,871		61
62	ROOF	1998	79,000	3,950	20	3,950		17,446		62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 8,227,268	\$ 278,693		\$ 229,441	\$ (49,252)	\$ 3,465,151		70

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

## STATE OF ILLINOIS

Page 12B

Facility Name &amp; ID Number Alden Valley Ridge Rehab &amp; HCC

# 0036640

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		
1	Totals from Page 12A, Carried Forward	\$ 8,227,268	\$ 278,693		\$ 229,441	\$ (49,252)	\$ 3,465,151		1
2	OIL/DRIER ON STAGE COMPRESSOR	1998 2,900	193	15	193		918		2
3	REPAIR TOWER	1998 2,727	182	15	182		818		3
4	REPLACE PRESSURE RELIEF VALVE	1998 1,940	129	15	129		582		4
5	CARPETING	1998 1,667	333	5	333		1,473		5
6	CARPETING	1998 15,858	3,172	5	3,172		13,743		6
7	CARPETING	1998 5,000	1,000	5	1,000		4,333		7
8	REPAIR FUEL PUMP ON GENERATOR	1998 2,532	127	20	127		549		8
9	FLOOR TILE	1998 4,876	488	10	488		2,072		9
10	REPAIR SHAFT AND GEAR REDUCER ON DRYER	1998 2,058	206	10	206		875		10
11	REPAIR VALVE IN THERAPY ROOM	1998 1,505	100	15	100		418		11
12	REPLACE HEAT PUMP	1998 3,773	252	15	252		1,048		12
13	CARPETING	1998 20,000	4,000	5	4,000		16,667		13
14	CARPETING	1998 18,082	3,616	5	3,616		15,069		14
15	Alden Bennet Construction (tank replacement)	1999 12,409	827	15	827		3,240		15
16	Northtown (repair dishwasher)	1999 1,695	170	10	170		664		16
17	Climate Service (replace hot water heater)	1999 9,561	637	15	637		2,390		17
18	Taylor Plumbing (pump repair)	1999 1,728	346	5	346		1,296		18
19	Ashland Plumbing & Heating Co. (furnished and installed ejector pump)	1999 6,658	444	15	444		1,628		19
20	Rykoff-Sexton (booster heater)	1999 1,893	189	10	189		694		20
21	Climate Service (cleaned condenser and tower)	1999 2,642	264	10	264		947		21
22	Patten Industries(generator repair)	1999 2,870	287	10	287		1,005		22
23	Fox Valley Fire & Safety(nurse call system repair)	1999 1,510	101	15	101		327		23
24	Fox Valley Fire & Safety(nurse call system repair)	1999 1,632	109	15	109		354		24
25	Climate Service(repair tower fan)	1999 4,733	473	10	473		1,538		25
26	Climate Service(repair tower fan)	1999 2,405	241	10	241		782		26
27	New Horizons(replace power supply for phone system)	1999 3,767	377	10	377		1,224		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,363,690	\$ 296,957		\$ 247,705	\$ (49,252)	\$ 3,539,804		34

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

Facility Name &amp; ID Number Alden Valley Ridge Rehab &amp; HCC

# 0036640

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		
1	<b>Totals from Page 12B, Carried Forward</b>	\$ 8,363,690	\$ 296,957		\$ 247,705	\$ (49,252)	\$ 3,539,804		1
2	Patten Industries(rebuild generator)	1999 7,884	394	20	394		1,215		2
3	Alco(nuts, bolts, lock extensions, tube cap,head screw)	1999 1,779	356	5	356		1,097		3
4	System Electric(repair dedicated circuits)	2000 2,461	164	15	164		479		4
5	Capps Plumbing (repair ejector pumps)	2000 4,970	331	15	331		966		5
6	Fox Valley (re-wire smoke detectors)	2000 14,576	1,458	10	1,458		4,008		6
7	Harold(repair dish machaine)	2000 962	192	5	192		449		7
8	Harold(repair dish machaine)	2000 1,328	266	5	266		597		8
9	new horizons-install phone line	2000 2,742	274	10	274		686		9
10	CSI -Coker Service (new motor)	2001 3,865	386	10	386		709		10
11	State mandated tank removal	2001 12,242	816	15	816		1,632		11
12	Water Pump repair	2001 1,706	341	5	341		540		12
13	GT (new shaft)	2001 2,491	498	5	498		706		13
14	new horizons-install phone line	2001 1,572	314	5	314		419		14
15	GT (replace fan blade)	2001 3,534	707	5	707		942		15
16	Alco sales & service (beds)	2001 2,324	232	10	232		310		16
17	Alco sales & service (beds)	2001 233	23	10	23		29		17
18	GT (repalace motor)	2001 791	79	10	79		99		18
19	GT (replace heat exchanger)	2001 1,332	266	5	266		311		19
20	GT (repair leaking piping)	2001 1,381	276	5	276		322		20
21	GT (refund for shaft)	2002 (2,491)	(498)	5	(498)		(498)		21
22	ABC (misc. repair)	2002 2,126	425	5	425		425		22
23	GT (compressor)	2002 4,290	95	15	95		95		23
24	Capps (install drain)	2002 2,585	474	5	474		474		24
25	SMT healthcare system(body lift)	2002 10,132	394	15	394		394		25
26	ABC --(carpet in two elevators))	2002 1,279	107	10	107		107		26
27	ABC (new gate)	2002 3,362	168	10	168		168		27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 8,453,145	\$ 305,497		\$ 256,245	\$ (49,252)	\$ 3,556,485		34

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

Facility Name &amp; ID Number Alden Valley Ridge Rehab &amp; HCC

# 0036640

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		
1	Totals from Page 12C, Carried Forward	\$ 8,453,145	\$ 305,497		\$ 256,245	\$ (49,252)	\$ 3,556,485		1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20		19,335		4
5	Leasehold Improvement-Remodeling	1980	1,208		10		1,208		5
6	Leasehold Improvement-Remodeling	1986	645		5		645		6
7	Leasehold Improvement-Remodeling	1990	404		5		404		7
8	Leasehold Improvement-Remodeling	1991	94		5		94		8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830	8,304		9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469	6,504		10
11	Leasehold Improvement-sign	1994	261	22	12	22	174		11
12	Leasehold Improvement-dryvit	1995	443	44	10	44	310		12
13	Leasehold Improvement-new ac	1999	723	48	15	48	145		13
14	Leasehold Improvement-roof	1985	972	52	19	52	922		14
15	Leasehold Improvement-roof	1994	863	58	15	58	518		15
16	Leasehold Improvement-roof	1997	819	55	15	55	328		16
17	Leasehold Improvement-roof	1998	1,390	93	15	93	464		17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11	33		18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16	32		19
20	Leasehold Improvement-DAI	2001	195	19	10	19	38		20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69	69		21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20	20		22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7		4,266		24
25	Leasehold Improvement-Remodeling	1994	2,112		7		2,112		25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	338	40	338	183		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,509,719	\$ 307,641		\$ 258,389	\$ (49,252)	\$ 3,602,593		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	\$ 868,225	\$ 54,883	\$ 54,883	\$	VARIOUS	\$ 668,333	71
72	Current Year Purchases	68,820	4,701	4,701		VARIOUS	4,701	72
73	Fully Depreciated Assets	116,319	170	170		VARIOUS	116,319	73
74								74
75	TOTALS	\$ 1,053,364	\$ 59,754	\$ 59,754	\$		\$ 789,353	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	bus	midwest transit bus '01	'01	49,826	9,965	9,965		3	19,930	77
78										78
79										79
80	TOTALS			\$ 62,162	\$ 13,757	\$ 13,757	\$		\$ 29,922	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,942,468	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 381,152	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 331,900	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (49,252)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,421,869	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.

**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?  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>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</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: \$ 8,927 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>various</u>	<u>various</u>	\$ <u>1,611.17</u>	\$ <u>19,334</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>1,611.17</u>	\$ <u>19,334</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>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.</p> <p><u>Skilled nurses on sight</u></p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER 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)	\$			

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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 204,141	\$	\$	204,141	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			46,253			46,253	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			257,250			257,250	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			80,105			80,105	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				(30,228)			(30,228)	13
14	TOTAL			\$		\$ 557,521	\$	\$	557,521	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 Valley Ridge Rehab &amp; HCC

# 0036640

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	\$ 159,413	\$ 182,254	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 207,456 )	1,652,941	1,652,941	3
4 Supply Inventory (priced at )	587	587	4
5 Short-Term Investments		275,416	5
6 Prepaid Insurance	5,898	5,898	6
7 Other Prepaid Expenses	62	44,457	7
8 Accounts Receivable (owners or related parties)		295,094	8
9 Other(specify): <u>Due from IDPA</u>	6,694	6,694	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,825,594	\$ 2,463,340	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments		13,817	12
13 Land		290,687	13
14 Buildings, at Historical Cost		8,011,971	14
15 Leasehold Improvements, at Historical Cost	514,262	717,762	15
16 Equipment, at Historical Cost	361,868	960,802	16
17 Accumulated Depreciation (book methods)	(578,390)	(4,074,715)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (spe <u>automobiles</u> )	49,826	49,826	22
23 Other(specify):			23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 347,566	\$ 5,970,150	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,173,160	\$ 8,433,490	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 398,300	\$ 398,300	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	282,507	282,507	28
29 Short-Term Notes Payable	15,909	96,085	29
30 Accrued Salaries Payable	278,928	278,928	30
31 Accrued Taxes Payable (excluding real estate taxes)	48,375	48,375	31
32 Accrued Real Estate Taxes(Sch.IX-B)		148,300	32
33 Accrued Interest Payable		44,232	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <u>Other accrued expenses/dueto BBS</u>	410,545	422,474	36
37 <u>Due to affiliates</u>	410,901	498,302	37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,845,465	\$ 2,217,503	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable	304,440	9,283,571	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 <u>trade note payables</u>	41,703	41,703	43
44 <u>Shareholder note/ payable</u>	437,600	1,046,319	44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 783,743	\$ 10,371,593	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,629,208	\$ 12,589,096	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ (456,048)	\$ (4,155,606)	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,173,160	\$ 8,433,490	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (630,052)	1
2	Restatements (describe):		2
3	External audit adjustments made after 2001 cost report	(150,001)	3
4	was submitted. These have no effect on prior years report:		4
5	Bad debt , medicare revenues (non-allowables)		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (780,053)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	324,005	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>\$ 324,005</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>\$ (456,048)</b>	24 *

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

Facility Name &amp; ID Number Alden Valley Ridge Rehab &amp; HCC

# 0036640

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	\$ 8,442,529	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,442,529	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	66,913	5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 66,913	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	<b>RECOVERY OF BAD DEBT</b>	14,713	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 14,713	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,524,156	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,421,340	31
32	Health Care	2,829,450	32
33	General Administration	2,275,738	33
<b>B. Capital Expense</b>			
34	Ownership	1,186,877	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	891,321	35
36	Provider Participation Fee	113,333	36
<b>D. Other Expenses (specify):</b>			
37	Related party salary allocations	(517,908)	37
38	transactions not included on this page, but included		38
39	on page 3 & 4.		39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,200,151	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	324,005	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 324,005	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 Valley Ridge Rehab & HCC

# 0036640

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	1,800	1,856	\$ 57,459	\$ 30.96	1
2	Assistant Director of Nursing	2,082	2,114	58,173	27.52	2
3	Registered Nurses	21,842	22,963	605,983	26.39	3
4	Licensed Practical Nurses	25,945	27,353	593,815	21.71	4
5	Nurse Aides & Orderlies	72,480	75,576	918,641	12.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	872	888	8,247	9.29	9
10	Activity Assistants	5,342	5,495	49,822	9.07	10
11	Social Service Workers	1,720	1,840	33,088	17.98	11
12	Dietician					12
13	Food Service Supervisor	1,936	1,960	25,543	13.03	13
14	Head Cook	6,462	7,211	72,046	9.99	14
15	Cook Helpers/Assistants	26,244	28,357	219,554	7.74	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,080	29,563	14.21	17
18	Housekeepers	20,126	21,428	170,910	7.98	18
19	Laundry	6,741	7,170	51,405	7.17	19
20	Administrator					20
21	Assistant Administrator	1,248	1,280	27,260	21.30	21
22	Other Administrative	7,455	8,017	122,654	15.30	22
23	Office Manager	755	901	13,137	14.58	23
24	Clerical	4,211	4,412	50,527	11.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,552	2,640	68,920	26.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,840	2,080	41,149	19.78	31
32	Other Health C: Clinical SS	1,670	1,918	41,638	21.71	32
33	Other(specify) ALZHEIMERS	5,659	5,913	76,151	12.88	33
34	TOTAL (lines 1 - 33)	220,902	233,452	\$ 3,335,685 *	\$ 14.29	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	\$ (2,961)	1-3	35
36	Medical Director	Monthly 19,500	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 4,968	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	8 432	11-3	44
45	Social Service Consultant	4 222	11-3	45
46	Other(specify)			46
47	Psycho-social consultant	47 2,515	11-3	47
48				48
49	TOTAL (lines 35 - 48)	59 \$ 24,676		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

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	
Bueno, L.	administrator	0	\$ 34,681	Workers' Compensation Insurance	\$ 70,511	IDPH License Fee	\$	
				Unemployment Compensation Insurance	23,946	Advertising: Employee Recruitment		
				FICA Taxes	253,411	Health Care Worker Background Check (Indicate # of checks performed)		
Palazzo, J.	administrator	0	50,000	Employee Health Insurance	98,538	Surety bond fees, dues & subscriptions	2,366	
				Employee Meals	35,086	IL Health Care Assoc	10,938	
various executives/assist admin	executive admin.	0	81,742	Illinois Municipal Retirement Fund (IMRF)*		Employee Assoc. Due	111	
				Related party - FECH union, health, welfare	1,413	Various	433	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 166,423	dental, life, pension costs	1,229	related party-ams	436	
B. Administrative - Other				relations, miscell, & background chks	9,818	Less: Public Relations Expense	( )	
Description			Amount	drug test, 401k match, vaccinations	3,847	Non-allowable advertising	( )	
			\$	Tuition Reimbursement	640	Yellow page advertising	( )	
				related party-ams	66,649			
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 565,088	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,285	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Alden Management Services	MNGT. FEES		\$ 761,308					
BDO	ACCT. FEES		6,734				In-State Travel	
Ken Fisch/Greenburg	Legal Fees		26,289				misc/gas/repairs	7,175
Janet Hermann	Legal Fees		481				related party-ams	12,995
Medicom	Software consultant		346				Seminar Expense	
Talx Corp	Work comp consulting		880				Comprehensive Therapeutics	750
Barry Greenburg/Hermann/Fisch	Legal consultations		536				O.C.C./Life Serv. Network	270
Various	Miscell.		114				Other	427
Epic Group	Marketing fees		4,000				Entertainment Expense	( )
US Gas & Energy	Utilities		2,295				(agree to Sch. V, line 24, col. 8)	
Comprehensive Therapeutics	Social serv/activity *		1,080				TOTAL	\$ 21,617
* reclassified to line 11								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 804,064	TOTAL			\$	

\* 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	Painting/hvac/pump rep's	2-10/92	\$ 6,223	5	\$	\$	\$	\$	\$	\$	\$	\$
2	Plumbing/painting	7-10/94	10,767	5	1,460							
3	Painting/hvac repairs	1-12/95	14,370	3-10	0							
4	Painting/hvac damper rep	1-12/96	21,136	3-10	2,838	656	656	656	656	656	656	
5	sprinklers/hvac repairs	5-11/97	12,867	3	4,289	2,989	0					
6	hvac repair	6/98	2,089	3	696	696	290	0				
7	painting>\$1,500 ytd 1999	7/99	10,794	3	1,799	3,598	3,598	1,799	0			
8	ABC(repair pole)	9/00	1,278	3		142	426	426	284	0		
9	GT Mech.(repair A/C)	8/00	1,545	3		214	515	515	301	0		
10	painting>\$1,500 ytd 2000	7/00	10,444	3		1,741	3,481	3,481	1,741	0		
11	CSI (repalce boiler)	5/01	4,312	3			958	1,437	1,437	480		
12	Capps Plumbing	9/01	1,645	3			183	548	548	366		
13	ABC (misc repairs)	10/02	1,392	3				116	464	464	348	
14	GT (cooling tower repair)	7/02	2,216	3				369	739	739	369	
15	ABC (misc repairs)	9/02	1,774	3				197	591	591	395	
16												
17												
18												
19												
20	TOTALS		\$ 102,852		\$ 11,082	\$ 10,036	\$ 10,107	\$ 9,544	\$ 6,761	\$ 3,296	\$ 1,768	\$

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. IL Healthcare Assoc. \$10,938
- (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. \$ 25,709 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. \$ \_\_\_\_\_  
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. \$ 35,086 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (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. \$ n/a
  - c. What percent of all travel expense relates to transportation of nurses and patients? 0
  - 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.