

		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042010

Facility Name: Alden Des Plaines Rehab & HC

Address: 1221 East Golf Road Des Plaines 60016
 Number City Zip Code

County: Cook

Telephone Number: (847) 768-1300 Fax # (847) 768-1668

IDPA ID Number: 36-4271650

Date of Initial License for Current Owners: 10/31/2000

Type of Ownership:

<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
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: _____ **Telephone Number:** () _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Joan Carl</u>	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</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>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>739</u>	<u>6,226</u>	<u>21,112</u>	<u>28,077</u>	8
9	SNF/PED					9
10	ICF	<u>706</u>	<u>965</u>		<u>1,671</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,445</u>	<u>7,191</u>	<u>21,112</u>	<u>29,748</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.09%

D. How many bed-hold days during this year were paid by the Department?

none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

noneF. Does the facility maintain a daily midnight census? yesG. 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 10/31/2000

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/31/2000 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number
of beds certified 110 and days of care provided 21,112Medicare Intermediary Administar Federal, Inc

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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
	A. General Services										
1	Dietary	493,886	31,522	7,058	532,466	749	533,215	(3,769)	529,446		1
2	Food Purchase		220,113		220,113	(20,192)	199,921	2,861	202,782		2
3	Housekeeping	135,899	18,889		154,788	634	155,422		155,422		3
4	Laundry	34,609	15,897		50,506	40	50,546		50,546		4
5	Heat and Other Utilities			193,165	193,165		193,165	(6,352)	186,813		5
6	Maintenance	45,548		115,684	161,232	109	161,341	4,650	165,991		6
7	Other (specify):* Security/Relatd party salary			124	124		124	26,634	26,758		7
8	TOTAL General Services	709,942	286,421	316,031	1,312,394	(18,660)	1,293,734	24,024	1,317,758		8
	B. Health Care and Programs										
9	Medical Director			62,400	62,400		62,400		62,400		9
10	Nursing and Medical Records	2,094,063	149,901	181,218	2,425,182	(79,426)	2,345,756	1,404	2,347,160		10
10a	Therapy	75,588			75,588		75,588		75,588		10a
11	Activities	97,339	1,337	2,884	101,560	86	101,646		101,646		11
12	Social Services	41,789			41,789		41,789		41,789		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Relatd party salary							15,049	15,049		15
16	TOTAL Health Care and Programs	2,308,779	151,238	246,502	2,706,519	(79,340)	2,627,179	16,453	2,643,632		16
	C. General Administration										
17	Administrative	102,292			102,292		102,292		102,292		17
18	Directors Fees										18
19	Professional Services			862,908	862,908		862,908	(829,171)	33,737		19
20	Dues, Fees, Subscriptions & Promotions			71,524	71,524	(4,878)	66,646	(58,405)	8,241		20
21	Clerical & General Office Expenses	293,748	19,502	74,657	387,907	4,534	392,441	(97,199)	295,242		21
22	Employee Benefits & Payroll Taxes			482,182	482,182	14,224	496,406	(20,744)	475,662		22
23	Inservice Training & Education					83,495	83,495		83,495		23
24	Travel and Seminar			6,802	6,802	625	7,427	8,601	16,028		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			121,567	121,567		121,567	13,692	135,259		26
27	Other (specify):* Bad debt/Relatd party salary			45,661	45,661		45,661	207,630	253,291		27
28	TOTAL General Administration	396,040	19,502	1,665,301	2,080,843	98,000	2,178,843	(775,596)	1,403,247		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,414,761	457,161	2,227,834	6,099,756		6,099,756	(735,119)	5,364,637		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Des Plaines Rehab & HC

#0042010

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	
	D. Ownership											
30	Depreciation			63,730	63,730		63,730	230,438	294,168			30
31	Amortization of Pre-Op. & Org.							831	831			31
32	Interest			207,423	207,423		207,423	1,001,687	1,209,110			32
33	Real Estate Taxes							287,306	287,306			33
34	Rent-Facility & Grounds			1,244,829	1,244,829		1,244,829	(1,244,829)				34
35	Rent-Equipment & Vehicles			12,205	12,205		12,205	14,681	26,886			35
36	Other (specify):* MIP & Amortiz.							103,404	103,404			36
37	TOTAL Ownership			1,528,187	1,528,187		1,528,187	393,518	1,921,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,077,504	1,509,854	2,587,358		2,587,358	(75,609)	2,511,749			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,077,504	1,570,079	2,647,583		2,647,583	(75,609)	2,571,974			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,414,761	1,534,665	5,326,100	10,275,526		10,275,526	(417,210)	9,858,316			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 Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(49)	2		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	(90,935)	30		9
10	Interest and Other Investment Income	(312)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,784)	2		13
14	Non-Care Related Interest	(34,039)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,154)	21		17
18	Fines and Penalties	(192)	32		18
19	Entertainment	(3,406)	20		19
20	Contributions	(905)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,734)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(45,661)	27		24
25	Fund Raising, Advertising and Promotional	(52,676)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (242,847)		\$	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)	69,485	various	34
35	Other- Attach Schedule	(243,848)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (174,363)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (417,210)		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						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					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Des Plaines Rehab & HC

ID# 0042010

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (7,899)	5	1
2	Intercompany (AMS) interest (g/1 7031)	(27,702)	32	2
3	Misc income	(89)	21	3
4	Misc income - records (g/1 4977-100-001)	(155)	10	4
5	Marketing Mgr (g/1 6701-100-009)	(146,365)	21	5
6	Mktg Mgr employee benefits reduction	(20,744)	22	6
7	IL Health Care Assoc PAC dues (32.97%)	(1,728)	20	7
8	Back out vendor settlement cost for prior year	(200)	21	8
9	Back out LLC mtge int > CON asset limit	(193,381)	32	9
10	Back out LLC MIP exp > CON asset limit	(18,139)	36	10
11	Back out LLC bank charges	(1,322)	21	11
12	Add back w/o of prior yr's payable by LLC	175,618	19	12
13				13
14	Adj deferred maintenance exp to equal page 22's	(306)	6	14
15	Back out refundable legal exp (various vendors)	(1,436)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(243,848)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(3,769)	0	0	0	0	0	0	0	(3,769)	1
2	Food Purchase	(2,833)	0	0	5,694	0	0	0	0	0	0	0	2,861	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	(7,899)	0	1,547	0	0	0	0	0	0	0	0	(6,352)	5
6	Maintenance	(306)	0	4,605	0	0	0	351	0	0	0	0	4,650	6
7	Other (specify):*	0	0	23,183	3,451	0	0	0	0	0	0	0	26,634	7
8	TOTAL General Services	(11,038)	0	29,335	5,376	0	0	351	0	0	0	0	24,024	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(155)	0	0	3,834	(2,275)	0	0	0	0	0	0	1,404	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	15,049	0	0	0	0	0	0	0	0	15,049	15
16	TOTAL Health Care and Programs	(155)	0	15,049	3,834	(2,275)	0	0	0	0	0	0	16,453	16
	C. General Administration													
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	163,448	(167,855)	(824,764)	0	0	0	0	0	0	0	0	(829,171)	19
20	Fees, Subscriptions & Promotions	(58,715)	0	310	0	0	0	0	0	0	0	0	(58,405)	20
21	Clerical & General Office Expenses	(149,130)	1,322	16,246	12,405	21,958	0	0	0	0	0	0	(97,199)	21
22	Employee Benefits & Payroll Taxes	(20,744)	0	0	0	0	0	0	0	0	0	0	(20,744)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,601	0	0	0	0	0	0	0	0	8,601	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	13,563	129	0	0	0	0	0	0	0	0	13,692	26
27	Other (specify):*	(45,661)	0	210,447	18,357	24,487	0	0	0	0	0	0	207,630	27
28	TOTAL General Administration	(110,802)	(152,970)	(589,031)	30,762	46,445	0	0	0	0	0	0	(775,596)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(121,995)	(152,970)	(544,647)	39,972	44,170	0	351	0	0	0	0	(735,119)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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)	
	D. Ownership													
30	Depreciation	(90,935)	311,477	8,035	0	1,861	0	0	0	0	0	0	230,438	30
31	Amortization of Pre-Op. & Org.	0	0	831	0	0	0	0	0	0	0	0	831	31
32	Interest	(255,626)	1,212,783	36,283	0	4,126	4,121	0	0	0	0	0	1,001,687	32
33	Real Estate Taxes	0	282,310	3,382	0	1,614	0	0	0	0	0	0	287,306	33
34	Rent-Facility & Grounds	0	(1,244,829)	0	0	0	0	0	0	0	0	0	(1,244,829)	34
35	Rent-Equipment & Vehicles	0	0	14,681	0	0	0	0	0	0	0	0	14,681	35
36	Other (specify):*	(18,139)	121,543	0	0	0	0	0	0	0	0	0	103,404	36
37	TOTAL Ownership	(364,700)	683,284	63,212	0	7,601	4,121	0	0	0	0	0	393,518	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(221,627)	(143,618)	289,636	0	0	0	0	0	(75,609)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(221,627)	(143,618)	289,636	0	0	0	0	0	(75,609)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(486,695)	530,314	(481,435)	(181,655)	(91,847)	293,757	351	0	0	0	0	(417,210)	45

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 6L		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	\$ 1,244,829	Alden-Des Plaines Rehab and Health Care Center, LLC		\$	\$ (1,244,829) 1
2	V	32 Interest income/RR interest	71,736	Alden-Des Plaines Rehab and Health Care Center, LLC			(71,736) 2
3	V	19 Write off prior yr's payable	175,618	Alden-Des Plaines Rehab and Health Care Center, LLC			(175,618) 3
4	V	32 Interest on mortgage		Alden-Des Plaines Rehab and Health Care Center, LLC		508,714	508,714 4
5	V	19 Accounting/Prof Fees		Alden-Des Plaines Rehab and Health Care Center, LLC		7,763	7,763 5
6	V	21 Bank charges		Alden-Des Plaines Rehab and Health Care Center, LLC		1,322	1,322 6
7	V	33 Real estate taxes		Alden-Des Plaines Rehab and Health Care Center, LLC		282,310	282,310 7
8	V	26 Property & liability ins		Alden-Des Plaines Rehab and Health Care Center, LLC		13,563	13,563 8
9	V	32 Interest on mortgage		Alden-Des Plaines Rehab and Health Care Center, LLC		690,648	690,648 9
10	V	32 Interest on IOD loan		Alden-Des Plaines Rehab and Health Care Center, LLC		85,157	85,157 10
11	V	36 Mortgage insurance premium		Alden-Des Plaines Rehab and Health Care Center, LLC		64,781	64,781 11
12	V	30 Depreciation		Alden-Des Plaines Rehab and Health Care Center, LLC		311,477	311,477 12
13	V	36 Amortization		Alden-Des Plaines Rehab and Health Care Center, LLC		56,762	56,762 13
14	Total		\$ 1,492,183			\$ 2,022,497	\$ * 530,314 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional fees	\$ 833,329	Alden Management Services		\$ 8,565	\$ (824,764)	15
16	V	21 Clerical and G & A		Alden Management Services		16,246	16,246	16
17	V	5 Utilities		Alden Management Services		1,547	1,547	17
18	V	6 Maintenance		Alden Management Services		4,605	4,605	18
19	V	24 Travel & seminar		Alden Management Services		8,601	8,601	19
20	V	26 Insurance		Alden Management Services		129	129	20
21	V	20 Dues/subscriptions/fees etc		Alden Management Services		310	310	21
22	V	30 Depreciation		Alden Management Services		8,035	8,035	22
23	V	31 Amortization		Alden Management Services		831	831	23
24	V	33 Real estate taxes		Alden Management Services		3,382	3,382	24
25	V	35 Rent-equipment/vehicles		Alden Management Services		14,681	14,681	25
26	V	32 Interest		Alden Management Services		36,283	36,283	26
27	V	7 Salaries-general serv		Alden Management Services		23,183	23,183	27
28	V	15 Salaries-health care		Alden Management Services		15,049	15,049	28
29	V	27 Salaries-general admin		Alden Management Services		210,447	210,447	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		\$ 833,329			\$ 351,894	\$ * (481,435)	39

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

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	1 Dietary consultant	\$ 7,058	Prism Health Care		\$ 3,289	\$ (3,769)	15
16	V	7 Dietary salaries		Prism Health Care		3,451	3,451	16
17	V	2 Tube feeding		Prism Health Care		5,694	5,694	17
18	V	10 Equipment rental-patient care	3,060	Prism Health Care		6,894	3,834	18
19	V	39 Ancillary supplies	287,188	Prism Health Care		65,561	(221,627)	19
20	V	27 G & A salaries		Prism Health Care		18,357	18,357	20
21	V	21 G & A expenses		Prism Health Care		12,405	12,405	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		\$ 297,306			\$ 115,651	\$ * (181,655)	39

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

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	\$ 415,818	Forum Extended Care II		\$ 591,806	\$ 175,988	15
16	V	39 I.V.	374,204	Forum Extended Care II		54,662	(319,542)	16
17	V	39 Wound Vac	295	Forum Extended Care II		231	(64)	17
18	V	10 House Stock	11,436	Forum Extended Care II		10,142	(1,294)	18
19	V	10 Pharm Consult	7,645	Forum Extended Care II		6,664	(981)	19
20	V	27 Employ Vaccin	2,694	Forum Extended Care II		2,109	(585)	20
21	V	27 G & A Salaries		Forum Extended Care II		25,072	25,072	21
22	V	21 Gen'l & Admin		Forum Extended Care II		21,958	21,958	22
23	V	32 Interest		Forum Extended Care II		4,126	4,126	23
24	V	33 Real Estate Tax		Forum Extended Care II		1,614	1,614	24
25	V	30 Depreciation		Forum Extended Care II		1,861	1,861	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		\$ 812,092			\$ 720,245	\$ * (91,847)	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 Revenue - therapy	\$ 1,149,104	Community Physical Therapy		\$ 1,438,740	\$ 289,636	15
16	V	32 Interest		Community Physical Therapy		4,121	4,121	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,149,104			\$ 1,442,861	\$ * 293,757	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	6	Repairs & maintenance	\$ 14,941	Alden Bennett Construction		\$ 15,292	\$ 351	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			\$ 14,941			\$ 15,292	\$ *	351	39

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Nursing Center - Des Plaines

42010

Report Period Beginning 01/01/05

Ending: 12/31/05

Note: ANC = Alden Nursing Center

RELATED NURSING HOMES	
Name	City
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Waterford	Aurora
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Northmoor	Chicago
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Clinton, WI
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Prism Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

IDPH Facility Number #42010
 Reporting Period Beginning 1/01/05
 Reporting Period Ending 12/31/05

Investor List

NAME	
STUART GOLDSAND	4
JULIAN BAILES MD	1
AARON CARL	1
MILDRED SCHLOSSBERG	5
JOHN VERCILLO	3
BRETT CARL	1
FLOYD A. SCHLOSSBERG	37 bought 8
FAS OF PTN	unsold 9
FAS OF CORP	dev. 20
AMS OF PTN (FAS OWNS 'S' CORP)	total 37
JOAN/SAM CARL	Bought 6, Dev 9 3 total 9
WILLIAM HOLWAY	2
RICHARD KERN TRUST	1
RITCHIE SCHULLO IRA	1
RANDI SCHULLO	2 Dev. 2
JAMES FREY	2
AUDRA ELISCO	1
AMI PISSETZKY	1 LOAN 1
DAVID MENN	1
HERSHEL HERRENDORF	1
HARVEY & MARCIA BRIN	1
LAUREN & TERRY MAGNUSSION	1
JAMES HALLBERG TRUST	3
SCOTT CASTY	10
JOSEPH GARCIA	2
ROBERT & DEANNA CARAS	1
RONALD & ANNETTE CARAS	1
LISA & JEFFREY DELDIN	1
ROSS DEUTSCH	1
JAMIE GOLDSAND-SULLIVAN	1
KENNETH & JERRI SUE GOLDSAND	1
TERI HALL	1
ROBERT HOWORTH	1
GARY & PAULA LEV	2
TOTALS	<u>100</u>

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	Chief Executive	37.00	135,871	1.04	2.60	salary	\$ 3,629	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.50	73,783	1.04	2.60	salary	1,971	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.50	50,160	1.04	2.60	salary	1,340	7-7	3
4	Joan Carl d.	Secretary	Vice-President	9.00	135,871	1.04	2.60	salary	3,629	27-7	4
5	Ami Pissetzky e.	Financial Service	Invest/Banking	1.00	135,871	1.04	2.60	salary	3,629	27-7	5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12	e. Ami Pissetzky is the Director of Finance. He has an interest in the real estate of Des Plaines.										12
13								TOTAL	\$ 14,198		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 Des Plaines Rehab & HC

0042010 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	See Page 8A (also on Page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1	Cambridge Realty		X	Mortgage	\$53,475.00	9/1/2005	\$ 10,390,300	\$ 10,376,833	4/1/2044	5.4000	\$ 140,073	1								
2	Cambridge Realty		X	Operating loss loan	\$8,538.00	3/1/2004	1,690,000	1,661,775	6/1/2040	5.1000	85,157	2								
3				Int exp in excess of CON cap							(193,381)	3								
4	Bank Leumi		X	Working capital	varies	5/31/2005	1,185,000	1,184,000	6/1/2006	varies	75,065	4								
5	Cambridge Realty		X	Mortgage		1/1/2002	10,390,300	refinanced		7.2000	1,059,289	5								
Working Capital																				
6	Related party-AMS	X		Working capital							36,283	6								
7	Related party-FECHII	X		Working capital							4,126	7								
8	Related party-CPT	X		Working capital							4,121	8								
9	TOTAL Facility Related				\$62,013.00		\$ 23,655,600	\$ 13,222,608			\$ 1,210,733	9								
B. Non-Facility Related*																				
10	DP Rehab & HCC, LCC	X		Interest-Replacement Res							(1,311)	10								
11	Patient interest income		X	Non-care interest income							(312)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(1,623)	14								
15	TOTALS (line 9+line14)						\$ 23,655,600	\$ 13,222,608			\$ 1,209,110	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 64,781 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.)

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	277,800	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.)			\$	275,910	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,890)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	284,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	282,310	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	5,663	8	
		2001	112,958	9	
		2002	261,776	10	
		2003	269,644	11	
		2004	275,910	12	
Accrual based on 3% increase over prior year bills.					
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2004	\$			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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Des Plaines Rehab & HC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042010

CONTACT PERSON REGARDING THIS REPORT Steven M Kroll

TELEPHONE (773) 586-3883 FAX #: (773) 286-3743

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1. 09-17-200-128-0000	Nursing home facility	\$ 163,032.87	\$ 163,032.87
2. 09-17-200-129-000	Nursing home facility	\$ 112,877.74	\$ 112,877.74
3. See Attached	Related Party-Alden Mgmt Serv	\$ 130,007.00	\$ 3,382.00
4. See Attached	Related Party-FECII	\$ 15,792.00	\$ 1,614.00
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 421,709.61	\$ 280,906.61

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,490 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>51,490</u>	<u>2000</u>	<u>\$ 1,016,045</u>	1
2					2
3	TOTALS	51,490		\$ 1,016,045	3

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	110		2000	2000	6,986,060	242,149	40	174,652	(67,497)	\$ 985,230	4
5											5
6											6
7											7
8	Related party - Forum			1978	14,541		25			14,541	8
	Improvement Type**										
9		ISS/Chicago Sound & Communication(vent alarm interface)		2000	3,400	340	10	340		1,927	9
10		Alden Bennett Construction(multiple wireless install)		2001	4,894	489	10	489		2,284	10
11		Owners extras (change orders)		2000	524,876	26,244	20	26,244		142,154	11
12		Owners extras (change orders)		2000	12,972	648	20	648		3,513	12
13		ABC-parking lot sealcoat/stripe		2002	3,852	550	7	550		1,880	13
14		ABC-screened patio enclosure		2002	10,069	1,438	7	1,438		5,514	14
15		EWS Welding-alarm		2002	1,076	108	10	108		430	15
16		New Horizons-residents phones		2002	1,646	165	10	165		604	16
17		New Horizons-residents phones		2002	3,161	316	10	316		1,133	17
18		ABC-owners extras		2003	2,571	171	15	171		514	18
19		ABC-owners extras		2003	5,511	367	15	367		1,102	19
20											20
21		GT Mechanical, Inc - Exhaust fan		2004	1,588	159	10	159		304	21
22		ABC-Domestic water booster pump		2004	1,578	158	10	158		250	22
23		GT Mechanical, Inc - H/V/A/C repairs		2004	2,248	225	10	225		337	23
24		Capps Plumbing-line repairs		2004	1,243	50	25	50		70	24
25											25
26		GT Mechanical, Inc - Taco pumps on Boiler #2		2005	1,814	91	20	91		91	26
27		GT Mechanical, Inc - A/C parts replaced		2005	3,383	226	10	226		226	27
28		ABC [Stripe-It-Right]-Sealcoat,crackfill & stripe asphalt		2005	1,803	75	10	75		75	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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		\$ 7,588,286	\$ 273,969		\$ 206,472	\$ (67,497)	\$ 1,162,179	1
2									2
3	Related Party-Forum Prof Center Building:								3
4	Leasehold Improvement-Remodeling	1980	11,034		15			11,034	4
5	Leasehold Improvement-Remodeling	1980	17,284		20			17,284	5
6	Leasehold Improvement-Tenant Improvement	1987	893		13			893	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,203	200	16	200		2,204	8
9	Leasehold Improvement-Build.Improv.	1996	1,129	71	16	71		702	9
10	Leasehold Improvement-Asphalting	2000	88		3			88	10
11	Leasehold Improvement-DAI	2001	154	15	10	15		64	11
12	Leasehold Improvement-Bathrooms	2002	667	76	7	76		242	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		491	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,801	329	7	329		465	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	71		23			71	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	123	25	5	25		117	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	694	7	694		1,997	28
29	Leasehold Improvement-Remodeling	2003	5,085	726	7	726		2,072	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	12,928	306	30	306		2,139	33
34	TOTAL (lines 1 thru 33)		\$ 7,669,522	\$ 276,576		\$ 209,079	\$ (67,497)	\$ 1,222,319	34

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

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 682,515	\$ 95,327	\$ 71,889	\$ (23,438)	Various	\$ 336,493	71
72	Current Year Purchases	18,662	1,680	1,680		Various	1,680	72
73	Fully Depreciated Assets	60,268	1,444	1,444		Various	60,268	73
74								74
75	TOTALS	\$ 761,445	\$ 98,451	\$ 75,013	\$ (23,438)		\$ 398,441	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	Bus	2001	2001	\$ 49,826	\$ 9,965	\$ 9,965	\$	5	\$ 49,826	76
77	Related party-AMS	Various: Bus/Autos	1998-2004	4,706	111	111		3	4,638	77
78										78
79										79
80	TOTALS			\$ 54,532	\$ 10,076	\$ 10,076	\$		\$ 54,464	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)	\$ 9,501,544	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 385,103	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 294,168	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (90,935)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,675,224	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 12,205

Description: Copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related party - AMS</u>		\$ <u>1,223.42</u>	\$ <u>14,681</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>1,223.42</u>	\$ <u>14,681</u>	21

10. Effective dates of current rental agreement:

Beginning 7/1/2001

Ending 7/1/2008

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$ 1670k

13. /2007 \$ 1670k

14. /2008 \$ 835k

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 532,648	\$		\$ 532,648	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			85,925			85,925	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			835,791			835,791	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				591,806		591,806	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				289,636	175,943		465,579	13
14	TOTAL			\$		\$ 1,744,000	\$ 767,749		\$ 2,511,749	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

XIV. Special Services (Direct Cost)

Page 16
Col 5: PT,OT, & ST
Col 6: Supplies

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	Col. No.
1. OT	39-3	To Col 5	532,648.92
2. ST	39-3	To Col 5	85,924.76
3.			
4. PT	39-3	To Col 5	835,791.32
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			415,818.31
Manual Input from Related Party- Forum Drugs			175,988.00 see pg 6C
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	<u>591,806.31</u>
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00
Total Exceptional Care (Line 12, Col 8)			<u>0.00</u>
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	289,636.00 see pg 6D
Other			717,175.08
Manual Input: Related Party - Pyramid			(221,627.00) see pg 6B
Manual Input: Related Party FECII - I.V.			(319,541.00) see pg 6C
Manual Input: Related Party FECII - Wound Vac			(64.00) see pg 6C
Oxygen, from reclass worksheet			0
13. Col 6: Supplies Total		To Col 6	<u>175,943.08</u>
13. Total Line 13, Column 8			<u>465,579.08</u>
14. Total			<u><u>2,511,750.39</u></u>

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 9,838	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 70,000)	1,987,264	1,987,264	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		620,633	5
6	Prepaid Insurance		53,545	6
7	Other Prepaid Expenses	5,804	5,804	7
8	Accounts Receivable (owners or related parties)	584,533	3,196,158	8
9	Other(specify): Due from 3rd parties	41,563	79,596	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,619,164	\$ 5,952,838	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,003,985	13
14	Buildings, at Historical Cost		9,685,956	14
15	Leasehold Improvements, at Historical Cost	590,749	590,749	15
16	Equipment, at Historical Cost	269,439	1,309,356	16
17	Accumulated Depreciation (book methods)	(294,490)	(1,956,218)	17
18	Deferred Charges	200,000	200,000	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): Refinancing fees		215,394	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 765,698	\$ 11,049,222	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,384,862	\$ 17,002,060	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,530,630	\$ 1,530,630	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	126,178	126,178	28
29	Short-Term Notes Payable	1,654,388	1,654,388	29
30	Accrued Salaries Payable	332,494	332,494	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,618	57,618	31
32	Accrued Real Estate Taxes(Sch.IX-B)		284,200	32
33	Accrued Interest Payable	74,739	128,497	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accr'd exp, ins,sales tax	276,679	276,679	36
37	Deferred Revenue		505,535	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,052,726	\$ 4,896,219	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,038,607	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,038,607	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,052,726	\$ 16,934,826	46
47	TOTAL EQUITY (page 18, line 24)	\$ (667,864)	\$ 67,234	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,384,862	\$ 17,002,060	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,722,436)	1
2	Restatements (describe):		2
3	Income tax adjustment made after 2004 cost report	200,000	3
4	was submitted. This has no effect on prior year's report.		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,522,436)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	854,572	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 854,572	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (667,864)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 01/01/2005Ending: 12/31/2005**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,041,433	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,041,433	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,494	6
7	Oxygen	1,124	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 55,618	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	255	12
13	Barber and Beauty Care	1,734	13
14	Non-Patient Meals	49	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(14,595)	19
20	Radiology and X-Ray		20
21	Other Medical Services	35,924	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 31,108	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	312	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 312	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Page 19A</u>	1,627	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,627	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,130,098	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,312,394	31
32	Health Care	2,706,519	32
33	General Administration	2,080,843	33
B. Capital Expense			
34	Ownership	1,528,187	34
C. Ancillary Expense			
35	Special Cost Centers	2,587,358	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,275,526	40
41	Income before Income Taxes (line 30 minus line 40)**	854,572	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 854,572	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.

IDPH Facility Number #42010
 Reporting Period Beginning 1/01/05
 Reporting Period Ending 12/31/05

<u>Misc Income (G/L 4977)</u>		<u>Ref Line</u>
Miscellaneous (g/l 4977-100-000)	20.00	21
Record copies (g/l 4977-100-001)	155.25	10
Wage service fee (g/l 4977-100-006)	44.00	21
Donations (g/l 4977-100-023)	<u>25.00</u>	21
Total G/L 4977	244.25	
Meals-private only (g/l 4640-100-000)	368.50	
Adjustment to expense related to prior yr (gl 4983-100-000)	<u>1,013.76</u>	
Total of Page 19, Line 28	<u><u>1,626.51</u></u>	

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	631	631	\$ 22,580	\$ 35.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,881	24,644	768,040	31.17	3
4	Licensed Practical Nurses	13,808	14,390	380,127	26.42	4
5	CNAs & Orderlies	61,281	65,071	813,325	12.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,078	2,211	33,117	14.98	8
9	Activity Director	2,072	2,080	43,416	20.87	9
10	Activity Assistants	7,237	7,589	85,186	11.22	10
11	Social Service Workers	2,008	2,080	41,789	20.09	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,160	70,345	32.57	13
14	Head Cook	2,905	3,058	40,299	13.18	14
15	Cook Helpers/Assistants	37,115	39,387	383,242	9.73	15
16	Dishwashers					16
17	Maintenance Workers	1,984	2,080	45,548	21.90	17
18	Housekeepers	14,649	15,430	135,899	8.81	18
19	Laundry	3,217	3,511	34,609	9.86	19
20	Administrator	1,766	1,984	102,292	51.56	20
21	Assistant Administrator					21
22	Other Administrative	8,168	8,600	235,208	27.35	22
23	Office Manager	2,016	2,080	29,505	14.19	23
24	Clerical	3,229	3,423	29,035	8.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,597	2,749	77,359	28.14	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	101	130	1,369	10.53	31
32	Other Health Ca <u>Clinical SS</u>	1,283	1,379	42,471	30.80	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,186	204,667	\$ 3,414,761 *	\$ 16.68	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	\$ 7,058	1-3	35
36	Medical Director	Monthly	68,400	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,640	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				44
45	Social Service Consultant	11	644	11-3	45
46	Other(specify)				46
47	<u>Alzheimer's Consultant</u>	10	428	11-3	47
48					48
49	TOTAL (lines 35 - 48)	21	\$ 79,170		49

C. CONTRACT NURSES

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

Facility Name & ID Number Alden Des Plaines Rehab & HC

Report Period Beginning: 01/01/2005 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	HVAC compressor	1/2002	\$ 3,063	3	\$ 1,021	\$ 1,021	\$ 1,021	\$	\$	\$	\$	\$	\$
2													
3													
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19													
20	TOTALS		\$ 3,063		\$ 1,021	\$ 1,021	\$ 1,021	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Alden Des Plaines Rehab & HC

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 Health Care Assoc \$5,244
- (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. \$ 17,195 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,225
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,192 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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. \$ 0
- (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? n/a If no, please explain. audit not required
- (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.

IDPH Facility Number #42010
 Reporting Period Beginning 1/01/05
 Reporting Period Ending 12/31/05

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2	22	(20,192) 20,192	Employee Meal Employee Meal
22	1	(5,968) 749	Uniforms Uniforms
	3	634	Uniforms
	4	40	Uniforms
	6	109	Uniforms
	10	4,069	Uniforms
	11	86	Uniforms
	21	281	Uniforms
10	23	(83,495) 83,495	Med consult-Dart Med consult-Dart
21	24	(625) 625	Deming Training Deming Training
20	21	(1,853) 1,853	Resident criminal background cks Resident criminal background cks
20	21	(2,400) 2,400	eHealth Data Solutions eHealth Data Solutions
		<hr/> 0	Net should be 0