

		FOR OFF USE					

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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: 0038455

Facility Name: Alden Village Health Facility

Address: 267 East Lake Street Bloomington 60108
 Number City Zip Code

County: DuPage

Telephone Number: (630) 529-3350 **Fax #** (630) 529-9866

IDPA ID Number: 36-3845800

Date of Initial License for Current Owners: 11/02/92

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: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 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>Steven M. Kroll</u>	
	(Title) <u>Chief Financial Officer</u>	
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 Village Health Facility

0038455 Report Period Beginning: 01/01/05 Ending: 12/31/05

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		Skilled (SNF)			1
2	109	Skilled Pediatric (SNF/PED)	109	39,785	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	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					8
9	SNF/PED	35,760	112	392	36,264	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,760	112	392	36,264	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.15%

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

624 (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 11/01/92

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

YES Date 11/01/92 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

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 Village Health Facility # 0038455 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	179,415	17,436	9,600	206,451	780	207,231	(5,126)	202,105		1
2	Food Purchase		525,158		525,158	(19,352)	505,806	(292,575)	213,231		2
3	Housekeeping	137,884	22,767		160,651	694	161,345		161,345		3
4	Laundry	50,787	13,444		64,231		64,231		64,231		4
5	Heat and Other Utilities			116,257	116,257		116,257	143	116,400		5
6	Maintenance	27,461		86,980	114,441		114,441	6,381	120,822		6
7	Other (specify):* Related Party Salary							32,955	32,955		7
8	TOTAL General Services	395,547	578,805	212,837	1,187,189	(17,878)	1,169,311	(258,222)	911,089		8
	B. Health Care and Programs										
9	Medical Director			42,160	42,160		42,160		42,160		9
10	Nursing and Medical Records	2,712,442	146,226	4,076	2,862,744	406	2,863,150	3,132	2,866,282		10
10a	Therapy					106,585	106,585		106,585		10a
11	Activities		3,032	193,094	196,126		196,126		196,126		11
12	Social Services	86,641			86,641		86,641		86,641		12
13	CNA Training	19,679			19,679		19,679		19,679		13
14	Program Transportation										14
15	Other (specify):* Related Party Salary							18,345	18,345		15
16	TOTAL Health Care and Programs	2,818,762	149,258	239,330	3,207,350	106,991	3,314,341	21,477	3,335,818		16
	C. General Administration										
17	Administrative	91,607			91,607		91,607		91,607		17
18	Directors Fees										18
19	Professional Services			564,689	564,689		564,689	(529,318)	35,371		19
20	Dues, Fees, Subscriptions & Promotions			21,903	21,903	(1,413)	20,490	(12,322)	8,168		20
21	Clerical & General Office Expenses	166,983	14,674	20,952	202,609	917	203,526	36,514	240,040		21
22	Employee Benefits & Payroll Taxes			515,342	515,342	17,343	532,685	(50)	532,635		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,885	16,885	625	17,510	10,485	27,995		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			119,859	119,859		119,859	7,927	127,786		26
27	Other (specify):* Bad Debt/Related Party Salary			(3,127)	(3,127)		(3,127)	286,068	282,941		27
28	TOTAL General Administration	258,590	14,674	1,256,503	1,529,767	17,472	1,547,239	(200,696)	1,346,543		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,472,899	742,737	1,708,670	5,924,306	106,585	6,030,891	(437,441)	5,593,450		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 Village Health Facility #0038455 Report Period Beginning: 01/01/05 Ending: 12/31/05

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			59,181	59,181		59,181	36,336	95,517			30
31	Amortization of Pre-Op. & Org.							7,562	7,562			31
32	Interest			93,963	93,963		93,963	345,617	439,580			32
33	Real Estate Taxes							55,565	55,565			33
34	Rent-Facility & Grounds			624,303	624,303		624,303	(624,303)				34
35	Rent-Equipment & Vehicles			8,971	8,971		8,971	17,897	26,868			35
36	Other (specify):* Mortgage Insurance							28,431	28,431			36
37	TOTAL Ownership			786,418	786,418		786,418	(132,895)	653,523			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,834	106,585	137,419	(106,585)	30,834	(10,840)	19,994			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			427,557	427,557		427,557		427,557			42
43	Other (specify):* Training for DD's			992,031	992,031		992,031		992,031			43
44	TOTAL Special Cost Centers		30,834	1,526,173	1,557,007	(106,585)	1,450,422	(10,840)	1,439,582			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,472,899	773,571	4,021,261	8,267,731		8,267,731	(581,176)	7,686,555			45

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

Alden Nursing Center - Village
 Reporting Period Beginning
 Reporting Period Ending

1/1/05
 12/31/05

Page 4A

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2	22	(19,352)	Employee Meal
		19,352	Employee Meal
22		(2,009)	Uniforms
	1	780	Uniforms
	3	694	Uniforms
	4	0	Uniforms
	6	0	Uniforms
	10	406	Uniforms
	11	0	Uniforms
	21	129	Uniforms
			Uniforms
10	39	0	Oxygen
		0	Oxygen
10	23	0	Dart Chart Consulting
		0	Dart Chart Consulting
39	10A	(106,585)	CPT Costs (Village)
		106,585	CPT Costs (Village)
20	21	(788)	ECIN reclass
		788	ECIN reclass
20	24	(625)	Demming Training reclass
		625	Demming Training reclass
		<u>0</u>	Net should be 0

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	(87,555)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(37)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,479)	21		17
18	Fines and Penalties	(75)	32		18
19	Entertainment	(335)	20		19
20	Contributions	312	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	3,127	27		24
25	Fund Raising, Advertising and Promotional	(12,109)	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)	\$ (98,151)		\$	30

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)	(378,837)	Various	34
35	Other- Attach Schedule	(104,188)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (483,025)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (581,176)		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		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	
				51	
					52

Alden Village Health Facility

ID# 0038455

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (1,742)	5	1
2	Intercompany interest	(93,888)	32	2
3	Misc. income - general	(8)	21	3
4	Misc. income - jury duty	(34)	22	4
5	Misc. income - wage service fee	(16)	22	5
6	Adj deferred maint amort to correct detail amount	50	6	6
7	Back out LLC bank fees	(568)	19	7
8	Adj Leasehold Impr-SAGE differs from GL	334	30	8
9	Adj Major Repairs-SAGE differs from GL	934	30	9
10	Adj Equip Depre-SAGE differs from GL	905	30	10
11	Eliminate refundable legal fees	(3,608)	19	11
12	Back out donations	(568)	20	12
13	Eliminate Reputation Partners from pro fees	(5,979)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(104,188)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	(5,126)	0	0	0	0	0	0	0	(5,126)	1
2	Food Purchase	(37)	0	0	(292,538)	0	0	0	0	0	0	0	(292,575)	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	(1,742)	0	1,885	0	0	0	0	0	0	0	0	143	5
6	Maintenance	50	0	5,614	0	0	0	717	0	0	0	0	6,381	6
7	Other (specify):*	0	0	28,261	4,694	0	0	0	0	0	0	0	32,955	7
8	TOTAL General Services	(1,729)	0	35,760	(292,970)	0	0	717	0	0	0	0	(258,222)	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	0	0	0	3,834	(702)	0	0	0	0	0	0	3,132	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	18,345	0	0	0	0	0	0	0	0	18,345	15
16	TOTAL Health Care and Programs	0	0	18,345	3,834	(702)	0	0	0	0	0	0	21,477	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	(10,155)	4,843	(524,006)	0	0	0	0	0	0	0	0	(529,318)	19
20	Fees, Subscriptions & Promotions	(12,700)	0	378	0	0	0	0	0	0	0	0	(12,322)	20
21	Clerical & General Office Expenses	(1,487)	0	19,805	17,825	371	0	0	0	0	0	0	36,514	21
22	Employee Benefits & Payroll Taxes	(50)	0	0	0	0	0	0	0	0	0	0	(50)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10,485	0	0	0	0	0	0	0	0	10,485	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	7,770	157	0	0	0	0	0	0	0	0	7,927	26
27	Other (specify):*	3,127	0	256,543	26,378	20	0	0	0	0	0	0	286,068	27
28	TOTAL General Administration	(21,265)	12,613	(236,638)	44,203	391	0	0	0	0	0	0	(200,696)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,994)	12,613	(182,533)	(244,933)	(311)	0	717	0	0	0	0	(437,441)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/05 Ending:

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(85,382)	111,822	8,035	0	1,861	0	0	0	0	0	0	36,336	30
31	Amortization of Pre-Op. & Org.	0	6,549	1,013	0	0	0	0	0	0	0	0	7,562	31
32	Interest	(93,963)	394,897	44,231	0	70	382	0	0	0	0	0	345,617	32
33	Real Estate Taxes	0	51,415	4,123	0	27	0	0	0	0	0	0	55,565	33
34	Rent-Facility & Grounds	0	(624,303)	0	0	0	0	0	0	0	0	0	(624,303)	34
35	Rent-Equipment & Vehicles	0	0	17,897	0	0	0	0	0	0	0	0	17,897	35
36	Other (specify):*	0	28,431	0	0	0	0	0	0	0	0	0	28,431	36
37	TOTAL Ownership	(179,345)	(31,189)	75,299	0	1,958	382	0	0	0	0	0	(132,895)	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	(15,002)	2,403	1,759	0	0	0	0	0	(10,840)	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	(15,002)	2,403	1,759	0	0	0	0	0	(10,840)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(202,339)	(18,576)	(107,234)	(259,935)	4,050	2,141	717	0	0	0	0	(581,176)	45

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/05

Ending:

12/31/05

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
The Alden Group, Ltd.	100	See pg 6k		See pg 6k		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Income	\$ 624,303	Village II, Inc.	100.00%	\$	\$ (624,303)	1
2	V	32 Investment Income - RR	14,547	Village II, Inc.	100.00%		(14,547)	2
3	V	19 Accounting Fee		Village II, Inc.	100.00%	4,200	4,200	3
4	V	19 Misc. Admin Expense		Village II, Inc.	100.00%	643	643	4
5	V	33 Real Estate Tax		Village II, Inc.	100.00%	51,415	51,415	5
6	V	26 Property & Liability Insur		Village II, Inc.	100.00%	7,770	7,770	6
7	V	32 Interest On Mortg. Note		Village II, Inc.	100.00%	409,444	409,444	7
8	V	36 Mortgage Insurance Premium		Village II, Inc.	100.00%	28,431	28,431	8
9	V	30 Depreciation		Village II, Inc.	100.00%	111,822	111,822	9
10	V	31 Amortization		Village II, Inc.	100.00%	6,549	6,549	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 638,850			\$ 620,274	\$ * (18,576)	14

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

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	\$ 534,447	Alden Management Services, Inc.	0.00%	\$ 10,441	\$ (524,006)	15
16	V	21 Clerical and G & A		Alden Management Services, Inc.		19,805	19,805	16
17	V	5 Utilities		Alden Management Services, Inc.		1,885	1,885	17
18	V	6 Maintenance		Alden Management Services, Inc.		5,614	5,614	18
19	V	24 Travel & seminar		Alden Management Services, Inc.		10,485	10,485	19
20	V	26 Insurance		Alden Management Services, Inc.		157	157	20
21	V	20 Dues/subscriptions/fees etc		Alden Management Services, Inc.		378	378	21
22	V	30 Depreciation		Alden Management Services, Inc.		8,035	8,035	22
23	V	31 Amortization		Alden Management Services, Inc.		1,013	1,013	23
24	V	33 Real estate taxes		Alden Management Services, Inc.		4,123	4,123	24
25	V	35 Rent-equipment/vehicles		Alden Management Services, Inc.		17,897	17,897	25
26	V	32 Interest		Alden Management Services, Inc.		44,231	44,231	26
27	V	7 Salaries-general serv		Alden Management Services, Inc.		28,261	28,261	27
28	V	15 Salaries-health care		Alden Management Services, Inc.		18,345	18,345	28
29	V	27 Salaries-general admin		Alden Management Services, Inc.		256,543	256,543	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		\$ 534,447			\$ 427,213	\$ * (107,234)	39

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

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 Con.	\$ 9,600	Prism Health Care	0.00%	\$ 4,474	\$ (5,126)	15
16	V	7 Dietary Salary		Prism Health Care		4,694	4,694	16
17	V	2 Tube Feeding	389,741	Prism Health Care		97,203	(292,538)	17
18	V	10 Equipment Rental	3,060	Prism Health Care		6,894	3,834	18
19	V	39 Supplies	24,814	Prism Health Care		9,812	(15,002)	19
20	V	39 Vent Rent		Prism Health Care				20
21	V	27 G&A Salary		Prism Health Care		26,378	26,378	21
22	V	21 G&A		Prism Health Care		17,825	17,825	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		\$ 427,215			\$ 167,280	\$ * (259,935)	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 Drugs	\$ 5,794	Forum Extended Care II	0.00%	\$ 8,246	\$ 2,452	15	
16	V	39 I.V.		Forum Extended Care II				16	
17	V	39 Wound Vac	226	Forum Extended Care II		177	(49)	17	
18	V	10 House Stock	3,236	Forum Extended Care II		2,870	(366)	18	
19	V	10 Pharm Consult.	2,616	Forum Extended Care II		2,280	(336)	19	
20	V	27 Employee Vaccinations	1,861	Forum Extended Care II		1,457	(404)	20	
21	V	27 G&A Salary		Forum Extended Care II		424	424	21	
22	V	21 General & Admin		Forum Extended Care II		371	371	22	
23	V	32 Interest		Forum Extended Care II		70	70	23	
24	V	33 Real Estate Tax		Forum Extended Care II		27	27	24	
25	V	30 Depreciation				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		\$ 13,733			\$ 17,783	\$ *	4,050	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39	Therapy	\$ 106,585	Community Physical Therapy	0.00%	\$ 108,344	\$ 1,759	15	
16	V	32	Interest		Community Physical Therapy	0.00%	382	382	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			\$ 106,585			\$ 108,726	\$ *	2,141	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	Maintenance Expense	\$ 30,574	Alden Bennett Construction	0.00%	\$ 31,291	\$ 717	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			\$ 30,574			\$ 31,291	\$ *	717 39

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

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NURSING CENTER - Village

42051

Report Period Beginning 01/01/05

Ending: 12/31/05

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
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	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Northmoor	Chicago
ANC Princeton	Chicago
Alden Orland Park	Orland Park
Alden of Old Town West	Bloomingtondale
Alden of Old Town East	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
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 Thereapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/05 Ending: 12/31/05

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/CFO	CEO	100% A	135,076	1.268	3.17	Salary	\$ 4,424	27-7	1
2	Lauren Magnusson	Clinical Coordinator	Nursing	B	73,351	1.268	3.17	Salary	2,403	15-7	2
3	Terry Magnusson	Maint. Superv.	Maint.	C	49,867	1.268	3.17	Salary	1,633	7-7	3
4											4
5											5
6	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,460		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 Village Health Facility

0038455

Report Period Beginning: 01/01/05

Ending: 12/31/05

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

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

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 (773-286-3473

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Cambridge		X	Mortgage	\$39,067.00	04/99	\$ 5,983,300	\$ 5,659,331	04/34	7.2000	\$ 409,444	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	CPT-Related Party	X		Working Capital							382	6								
7	FECII-Related Party	X		Working Capital							70	7								
8	AMS-Related Party	X		Working Capital							44,231	8								
9	TOTAL Facility Related				\$39,067.00		\$ 5,983,300	\$ 5,659,331			\$ 454,127	9								
B. Non-Facility Related*																				
10	Int Inc on Repl Reserve		X								(14,547)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(14,547)	14								
15	TOTALS (line 9+line14)						\$ 5,983,300	\$ 5,659,331			\$ 439,580	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,431 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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 48,900	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.)		\$ 49,415	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 515	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 50,900	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.		\$ 51,415	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	44,695	8
	2001	46,451	9
	2002	48,589	10
	2003	47,468	11
	2004	49,415	12
<u>current year accrual is an estimate based on a 3% increase on latest invoice.</u>			
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, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Village Health Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0038455

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 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)	(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>02-14-107-028</u>	<u>Nursing home</u>	\$ <u>46,118.64</u>	\$ <u>46,118.64</u>
2. <u>02-14-107-027</u>	<u>Nursing home</u>	\$ <u>3,296.06</u>	\$ <u>3,296.06</u>
3. <u>See Attached (Pgs 1-11)</u>	<u>Related Party - Alden Management</u>	\$ <u>130,007.00</u>	\$ <u>4,123.00</u>
4. <u>See Attached (Pgs 1-11)</u>	<u>Related Party - Forum</u>	\$ <u>15,792.00</u>	\$ <u>27.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>195,213.70</u>	\$ <u>53,564.70</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 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 Village Health Facility

0038455 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,726 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>		<u>1992</u>	<u>\$ 135,758</u>	1
2					2
3	TOTALS			\$ 135,758	3

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6	109		1992	1973	639,042		30			639,042	6
7			1984	1984	706,283	87,555	15		(87,555)	706,283	7
8		related partry-forum		1978	14,541		25			14,541	8
		Improvement Type**									
9		Repair Heater pump, replace temp controller		1992	2,131		10			2,131	9
10		Water heater moyor;valve repair		1993	9,288	101	5-15	101		9,010	10
11		Carpentry work, water heater repair		1994	63,064	2,677	3-15	2,677		54,586	11
12		Fire alarm repairs; brickwork; install circuits		1995	185,123	6,151	3-25	6,151		107,553	12
13		Village construction		1996	14,046	562	25	562		6,040	13
14		Install fire door		1996	2,977	198	15	198		1,952	14
15		Replace compressor		1997	1,825		5			1,825	15
16		Roof patching		1998	1,700	170	10	170		1,303	16
17		Replace condensing unit		1998	4,810	321	15	321		2,405	17
18		install damper motor & detector		1998	2,104	140	15	140		1,017	18
19		Replace furnace equipment		1999	1,827	122	15	122		853	19
20		install automatic door		1999	8,107	811	10	811		5,134	20
21		Install display and digital phones		2000	1,726	173	10	173		935	21
22		Replace HVAC burners		2000	1,607		3			1,607	22
23		Replace 5 ton condensing unit		2000	1,950	130	5	130		1,950	23
24		Install 100 amp disconnect and cable		2000	1,920	128	5	128		1,920	24
25		Roof repair		2000	1,583	237	5	237		1,557	25
26		Door Alarms		2001	19,015	1,902	10	1,902		8,557	26
27		Display phone and digital phone		2001	1,609	161	10	161		791	27
28		ABC (misc. repairs)		2002	2,362	472	5	472		1,889	28
29		Capps Plumbing (gas regulators for main gas to building)		2002	4,375	438	10	438		1,714	29
30		GT Mechanical (semi - hermetic compressor on RTU)		2002	5,350	535	10	535		1,917	30
31		ABC (wall mounted eye wash)		2002	2,507	251	10	251		857	31
32		ABC (misc. repairs)		2002	1,800	360	5	360		1,230	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	ABC=-Parking lot repairs	2003	\$ 20,730	\$ 2,073	10	\$ 2,073	\$	\$ 6,219	37
38	ABC- misc construction	2003	7,580	758	10	758		1,706	38
39	Capps basemetn sewers repairs	2003	2,970	990	3	990		2,888	39
40	ABC-roof repairs	2003	3,200	320	10	320		907	40
41	GT Mechanical-A/C repair	2003	1,773	355	5	355		886	41
42	Capps- install new shower drain	2003	1,215	61	20	61		132	42
43	Ruffino's Auto- bus repair	2003	1,697	567	3	567		1,225	43
44	Ruffino's Auto- braketransmission repair	2003	6,572	2,191	3	2,191		4,564	44
45	ABC- roof repair	2003	10,121	1,012	10	1,012		2,109	45
46	ABC - Electrical repairs	2004	9,474	632	15	632		1,211	46
47	Patton Ind-gernerator repair	2004	2,050	205	10	205		290	47
48	ABC - roof repairs	2004	1,918	192	10	192		288	48
49	GT Mechanical-heater repair	2004	1,506	151	10	151		176	49
50	GT Mechanical-heater repair	2004	1,878	188	10	188		203	50
51	ABC-roof repairs	2004	3,356	306	10	306		364	51
52	ABC-new tile	2004	9,043	904	10	904		1,658	52
53	ABC-doors	2004	3,293	220	15	220		402	53
54	ABC-roof canopy	2004	3,581	358	10	358		627	54
55	ABC-new 2nd water heater	2004	14,644	976	15	976		1,464	55
56	TNS, Inc-rewire for DSL	2004	1,512	151	10	151		290	56
57	ABC-various remodeling	2004	4,661	932	5	932		1,631	57
58	ABC-new water heater for kitchen	2004	14,644	976	15	976		1,464	58
59	ABC-bathroom remodel	2004	1,641	328	5	328		383	59
60	ABC-install metal door	2004	1,227	123	10	123		164	60
61	East Side Auto-bus repairs	2005	601	30	5	30		30	61
62	East Side Auto-bus repairs	2005	744		5				62
63	Capps Plumbing-install 2 discharge lines	2005	865	29	5	29		29	63
64	East Side Auto-bus repairs	2005	887	30	5	30		30	64
65	East Side Auto-bus repairs	2005	965	96	5	96		96	65
66	East Side Auto-bus repairs	2005	1,130	113	5	113		113	66
67	Patton Ind-gernerator repair	2005	1,747	175	5	175		175	67
68	Oak Fire-change out 30 detectors	2005	1,885	314	5	314		314	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,841,781	\$ 119,351		\$ 31,796	\$ (87,555)	\$ 1,610,637	70

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

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		\$ 1,841,781	\$ 119,351		\$ 31,796	\$ (87,555)	\$ 1,610,637	1
2	Equipment International-washer repairs	2005	1,905	64	5	64		64	2
3	East Side Auto-bus repairs	2005	2,062	241	5	241		241	3
4	East Side Auto-bus repairs	2005	2,239	75	5	75		75	4
5	ABC-firestop installation	2005	3,213	54	10	54		54	5
6	GT Mechanical-replace 5 ton York RTU	2005	6,160	257	10	257		257	6
7	East Side Auto-bus repairs	2005	6,254	834	5	834		834	7
8	GT Mechanical-replace storage tank	2005	8,935	745	10	745		745	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,872,549	\$ 121,621		\$ 34,066	\$ (87,555)	\$ 1,612,907	34

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

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		\$ 1,872,549	\$ 121,621		\$ 34,066	\$ (87,555)	\$ 1,612,907	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)		\$ 1,953,786	\$ 124,228		\$ 36,673	\$ (87,555)	\$ 1,673,047	34

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

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 545,359	\$ 45,847	\$ 45,847	\$	Various	\$ 279,436	71
72	Current Year Purchases	8,204	972	972		Various	972	72
73	Fully Depreciated Assets	193,911	2,047	2,047		Various	193,911	73
74								74
75	TOTALS	\$ 747,474	\$ 48,866	\$ 48,866	\$		\$ 474,319	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 Purch-Anrie Yusim		2004	\$ 45,183	\$ 9,037	\$ 9,037	\$	5	\$ 13,555	76
77	East Side Auto-lift for bus		2004	4,150	830	830		5	1,107	77
78	Related Party - AMS	Various Bus / Autos	98-'04	4,706	111	111		3	4,638	78
79	Bus Purch-AMS transfer		2000	49,938					49,938	79
80	TOTALS			\$ 103,977	\$ 9,978	\$ 9,978	\$		\$ 69,238	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)	\$ 2,940,995	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,072	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,517	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (87,555)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,216,604	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

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 8,971 Description: postage meter rental \$504; copy machine lease \$8467

(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>#####</u>	\$ <u>17,897</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>17,897</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 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 checked="" type="checkbox"/> YES <input 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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="text" value="12"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>COMMUNITY COLLEGE <input type="text"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="text" value="12"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>HOURS PER CNA <u>82</u></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)		3,660		3,660
4	Clinical Wages (b)		7,319		7,319
5	In-House Trainer Wages (c)		8,700		8,700
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 19,679	\$	\$ 19,679
10	SUM OF line 9, col. 1 and 2 (e)	\$	19,679		

C. CONTRACTUAL INCOME

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

\$ n/a

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>12</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

- (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	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	\$		\$ 23,873	\$		\$ 23,873	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,262			9,262	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			73,450			73,450	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16 A	# of prescripts				8,246		8,246	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Pg 16 A				1,759	9,989		11,748	13
14	TOTAL			\$		\$ 108,344	\$ 18,235		\$ 126,579	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.

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

XIV. Special Services (Direct Cost)

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	Col. No.
1. OT	39-3	To Col 5	\$23,872.69
2. ST	39-3	To Col 5	9,261.79
3.			
4. PT	39-3	To Col 5	73,450.46
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			5,793.97
Manual Input from Related Party- Forum Drugs			2,452.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	8,245.97
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)			0.00
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	1,759.00
Other			25,039.85
Manual Input: Related Party - Prism			(15,002.00)
Manual Input: Related Party FECII - I.V.			0.00
Manual Input: Related Party FECII - Wound Vac			(49.00)
Oxygen, from reclass worksheet			0.00
13. Col 6: Supplies Total		To Col 6	9,988.85
13. Total Line 13, Column 8			11,747.85
14. Total			126,578.76

Note: This total does not agree to page 4 line 39 due to a reclass specified on page 4A

Facility Name & ID Number Alden Village Health Facility# 0038455Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ (219,464)	\$ (219,221)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>zero</u>)	1,363,093	1,363,093	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	326	15,546	6
7	Other Prepaid Expenses	6,738	6,738	7
8	Accounts Receivable (owners or related parties)	2,148,519	2,562,207	8
9	Other(specify): <u>Due from 3rd parties</u>	175,050	175,050	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,474,262	\$ 3,903,413	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		580,000	13
14	Buildings, at Historical Cost		3,414,649	14
15	Leasehold Improvements, at Historical Cost	642,608	642,608	15
16	Equipment, at Historical Cost	399,806	763,806	16
17	Accumulated Depreciation (book methods)	(677,525)	(1,494,134)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		229,227	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(43,662)	20
21	Restricted Funds		1,451,666	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP Building</u>	9,900	222,961	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 374,789	\$ 5,767,121	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,849,051	\$ 9,670,534	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 556,097	\$ 556,607	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,500	6,500	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	326,527	326,527	30
31	Accrued Taxes Payable (excluding real estate taxes)	51,615	51,615	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,900	32
33	Accrued Interest Payable		33,956	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrd Exps / Due to IDPA</u>	16,776	16,776	36
37	<u>Accrd Day Training Exps</u>	304,476	304,476	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,261,991	\$ 1,347,357	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,659,331	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)	\$	\$ 5,659,331	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,261,991	\$ 7,006,688	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,587,060	\$ 2,663,846	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,849,051	\$ 9,670,534	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,728,958	1
2	Restatements (describe):		2
3	External audit adj made after 2004 cost	(5,649)	3
4	report was submitted. No effect on prior years report:		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,723,309	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(136,249)	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)	\$ (136,249)	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)	\$ 2,587,060	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Village Health Facility# 0038455Report Period Beginning: 01/01/05Ending: 12/31/05**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	\$ 7,042,431	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,042,431	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	32,762	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,296	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,058	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Page 19 A</u>	1,054,993	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,054,993	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,131,482	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,187,189	31
32	Health Care	3,207,350	32
33	General Administration	1,529,767	33
B. Capital Expense			
34	Ownership	786,418	34
C. Ancillary Expense			
35	Special Cost Centers	1,129,450	35
36	Provider Participation Fee	427,557	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,267,731	40
41	Income before Income Taxes (line 30 minus line 40)**	(136,249)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (136,249)	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.

Village Page 19A support

Alden Village
PA Pg 19 P & L
For the Thirteen Months Ending December 31, 2005

Column 1
Amount

Page 19A

Must be submitted if there is a balance on Line 28. You need only report the info that has a balance.

Miscellaneous Income gl 4977 (describe) (is offset againts Schdl V.)	58.40	
Offset G&A - backed out on page 5A ref line 21		8.00
Jury Duty- Backed out with line reference 22 on page 5A		34.40
Wage Service Fee- Backed out with line reference 22 on page 5A		16.00
		<hr/>
		58.40
Day Training Income (not offset, actual costs reported)	1,047,372.54	
Adjust prior year expenses (related to prior yr, not offset on Schdl V)	7,561.91	
	- - - - -	
Total of line 28	1,054,992.85	
	= = = = =	

PA Pg 19 P & L
03/10/06
12:00 PM

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/05

Ending:

12/31/05

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	1,272	1,520	\$ 52,971	\$ 34.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,949	22,318	612,318	27.44	3
4	Licensed Practical Nurses	9,767	10,451	242,488	23.20	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,464	1,464	10,980	7.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,188	19,745	179,414	9.09	15
16	Dishwashers					16
17	Maintenance Workers	1,088	1,368	27,461	20.07	17
18	Housekeepers	12,132	12,726	137,884	10.83	18
19	Laundry	5,260	5,522	50,787	9.20	19
20	Administrator	2,024	2,080	91,607	44.04	20
21	Assistant Administrator					21
22	Other Administrative	3,848	4,160	125,552	30.18	22
23	Office Manager	1,912	2,064	24,482	11.86	23
24	Clerical	2,153	2,214	16,951	7.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,016	6,144	86,641	14.10	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	159,073	166,692	1,793,083	10.76	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training Tran	1,690	1,690	20,280	12.00	33
34	TOTAL (lines 1 - 33)	246,836	260,158	\$ 3,472,899 *	\$ 13.35	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	\$ 9,600	1-3	35
36	Medical Director	Monthly	42,160	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,616	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	3,243	189,699	11-3	44
45	Social Service Consultant	44	2,564	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,287	\$ 246,639		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 Village Health Facility

Report Period Beginning: 01/01/05 Ending:

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	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Wash Condenser	5/93	\$ 3,238	10	\$ 324	\$ 108	\$	\$	\$	\$	\$	\$	\$
2	Circulator pump	11/94	2,100	10	210	210	175	0					
3	Compressor A/C	11/94	2,191	15	146	146	146	146	146	146	146		
4	Circulator Pump	1/95	1,621	10	162	162	162	0					
5	Relocating water pipe	7/95	1,908	15	127	127	127	127	127	127	127		
6	Rooftop repair	9/96	3,545	10	354	354	354	354					
7	Repair A/C	6/98	3,650	3	0								
8	Replace blowers	10/98	2,620	3	0								
9	replace blowers	10/98	2,115	3	0								
10	Thermometer on heater	8/99	1,502	3	292	0							
11													
12	Repair water main and tie	5/00	1,572	3	524	175	0						
13	Repair CAT equip	11/00	1,855	3	618	515	0						
14	General repairs	7/01	1,550	3	517	517	258	0					
15	RPZ repair and cert	7/01	2,781	3	927	927	541	0					
16	General repairs	9/01	1,766	3	589	589	442	0					
17	General Maintenance	11/01	2,362	3	787	787	722	0					
18	no new items for 2003/'04												
19	Heater repairs	02/05	1,550	5				285	310	310	310	310	26
20	TOTALS		\$ 37,926		\$ 5,577	\$ 4,616	\$ 2,926	\$ 912	\$ 583	\$ 583	\$ 583	\$ 310	\$ 26

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. IHCA \$6017
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 43,929 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. \$ 427,557
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. \$ 19,352 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? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
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? Yes
Firm Name: BDO Seidman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Yet Completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.