

		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: 0042077

Facility Name: Alden of Old Town West

Address: 118 South Bloomingdale Road Bloomington 60108
 Number City Zip Code

County: DuPage

Telephone Number: (630)671-1660 **Fax #** (630)671-0457

IDPA ID Number: 36-3966583

Date of Initial License for Current Owners: 05/19/98

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 of Old Town West

0042077 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		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,770</u>			<u>5,770</u>
14	TOTALS	<u>5,770</u>			<u>5,770</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.80%

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

70 (Do not include bed-hold days in Section B.)

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/19/88

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

YES Date 05/19/88 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 N/A

IV. ACCOUNTING BASIS

ACCURAL 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 of Old Town West # 0042077 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	52,523	3,381		55,904	80	55,984		55,984			1
2	Food Purchase		25,769		25,769	(2,228)	23,541		23,541			2
3	Housekeeping	13,489	6,141		19,630		19,630		19,630			3
4	Laundry		1,963		1,963		1,963		1,963			4
5	Heat and Other Utilities			15,429	15,429		15,429	9	15,438			5
6	Maintenance			28,326	28,326		28,326	928	29,254			6
7	Other (specify):* Related Party Salary							4,497	4,497			7
8	TOTAL General Services	66,012	37,254	43,755	147,021	(2,148)	144,873	5,434	150,307			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	360,235	15,665	894	376,794	532	377,326	(89)	377,237			10
10a	Therapy					5,833	5,833		5,833			10a
11	Activities		(36)	23,190	23,154		23,154		23,154			11
12	Social Services	29,285			29,285		29,285		29,285			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related Party Salary							2,919	2,919			15
16	TOTAL Health Care and Programs	389,520	15,629	28,084	433,233	6,365	439,598	2,830	442,428			16
	C. General Administration											
17	Administrative	18,059			18,059		18,059		18,059			17
18	Directors Fees											18
19	Professional Services			95,092	95,092		95,092	(85,400)	9,692			19
20	Dues, Fees, Subscriptions & Promotions			2,818	2,818		2,818	(1,132)	1,686			20
21	Clerical & General Office Expenses		3,180	9,792	12,972		12,972	2,295	15,267			21
22	Employee Benefits & Payroll Taxes			80,009	80,009	1,616	81,625		81,625			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,960	2,960		2,960	1,668	4,628			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,682	17,682		17,682	1,531	19,213			26
27	Other (specify):* Related Party Salary			(576)	(576)		(576)	41,476	40,900			27
28	TOTAL General Administration	18,059	3,180	207,777	229,016	1,616	230,632	(39,562)	191,070			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	473,591	56,063	279,616	809,270	5,833	815,103	(31,298)	783,805			29

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

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

Facility Name & ID Number Alden of Old Town West

#0042077

Report Period Beginning:

01/01/05

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			3,214	3,214		3,214	38,879	42,093			30
31	Amortization of Pre-Op. & Org.							763	763			31
32	Interest			21,979	21,979		21,979	55,112	77,091			32
33	Real Estate Taxes							14,186	14,186			33
34	Rent-Facility & Grounds			93,054	93,054		93,054	(93,054)				34
35	Rent-Equipment & Vehicles			4,758	4,758		4,758	2,848	7,606			35
36	Other (specify):*							6,602	6,602			36
37	TOTAL Ownership			123,005	123,005		123,005	25,336	148,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,098	5,833	6,931	(5,833)	1,098	(1,783)	(685)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,069	76,069		76,069		76,069			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,098	81,902	83,000	(5,833)	77,167	(1,783)	75,384			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	473,591	57,161	484,523	1,015,275		1,015,275	(7,745)	1,007,530			45

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

Alden of Old Town West
 Reporting Period Beginning 1/1/2005
 Reporting Period Ending 12/31/2005

Reclassifications

From Line	To Line	Amount	Description
2	22	(2,228.00)	Employee Meal
		2,228.00	Employee Meal
39	10	(5,716.00)	PT, ST, OT CPT
		5,716.00	PT, ST, OT CPT
22	1	(612.00)	Uniform Reclass
	3	80.00	Uniform Reclass
	4	0.00	Uniform Reclass
	6	0.00	Uniform Reclass
	10	532.00	Uniform Reclass
	11	0.00	Uniform Reclass
	21	0.00	Uniform Reclass
		<u>0.00</u>	Net

Facility Name & ID Number Alden of Old Town West

0042077

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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,044)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	3	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	577	27		24
25	Fund Raising, Advertising and Promotional	(904)	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)	\$ (1,368)		\$	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)	919	Various	34
35	Other- Attach Schedule	(7,296)	Page 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (6,377)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (7,745)		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

Alden of Old Town West

ID# 0042077

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late Fees on Utilities	\$ (291)	5	1
2	Intercompany Interest (gl 7031) eliminated	(7,020)	32	2
3	Back out 32.97% of PAC fees from IHCA bills	(291)	20	3
4	Kaxamias Construction (GL 7143)	(128)	6	4
5	Adj Depreciation to correct amount	486	30	5
6	Adj Deferred Maintenance to correct amount	(180)	6	6
7	Move settlement to correct account	128	21	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				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	(7,296)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town West

0042077

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	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(291)	0	300	0	0	0	0	0	0	0	0	9	5
6	Maintenance	(308)	0	893	0	0	0	343	0	0	0	0	928	6
7	Other (specify):*	0	0	4,497	0	0	0	0	0	0	0	0	4,497	7
8	TOTAL General Services	(599)	0	5,690	0	0	0	343	0	0	0	0	5,434	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	0	(89)	0	0	0	0	0	0	(89)	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	2,919	0	0	0	0	0	0	0	0	2,919	15
16	TOTAL Health Care and Programs	0	0	2,919	0	(89)	0	0	0	0	0	0	2,830	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	0	1,686	(87,086)	0	0	0	0	0	0	0	0	(85,400)	19
20	Fees, Subscriptions & Promotions	(1,192)	0	60	0	0	0	0	0	0	0	0	(1,132)	20
21	Clerical & General Office Expenses	(916)	0	3,151	31	29	0	0	0	0	0	0	2,295	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,668	0	0	0	0	0	0	0	0	1,668	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	1,506	25	0	0	0	0	0	0	0	0	1,531	26
27	Other (specify):*	577	0	40,819	46	34	0	0	0	0	0	0	41,476	27
28	TOTAL General Administration	(1,531)	3,192	(41,363)	77	63	0	0	0	0	0	0	(39,562)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,130)	3,192	(32,754)	77	(26)	0	343	0	0	0	0	(31,298)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town West

0042077

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	486	28,497	8,035	0	1,861	0	0	0	0	0	0	38,879	30
31	Amortization of Pre-Op. & Org.	0	602	161	0	0	0	0	0	0	0	0	763	31
32	Interest	(7,020)	55,068	7,038	0	6	20	0	0	0	0	0	55,112	32
33	Real Estate Taxes	0	13,528	656	0	2	0	0	0	0	0	0	14,186	33
34	Rent-Facility & Grounds	0	(93,054)	0	0	0	0	0	0	0	0	0	(93,054)	34
35	Rent-Equipment & Vehicles	0	0	2,848	0	0	0	0	0	0	0	0	2,848	35
36	Other (specify):*	0	6,602	0	0	0	0	0	0	0	0	0	6,602	36
37	TOTAL Ownership	(6,534)	11,243	18,738	0	1,869	20	0	0	0	0	0	25,336	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	(577)	86	(1,292)	0	0	0	0	0	(1,783)	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	(577)	86	(1,292)	0	0	0	0	0	(1,783)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(8,664)	14,435	(14,016)	(500)	1,929	(1,272)	343	0	0	0	0	(7,745)	45

Facility Name & ID Number Alden of Old Town West

0042077

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 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: 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 revenue	\$ 93,054	Alden of Bloomingdale Limited Partnership		\$	\$ (93,054)	1
2	V	32 Revenue from investments	14,959	Alden of Bloomingdale Limited Partnership			(14,959)	2
3	V	19 Audit		Alden of Bloomingdale Limited Partnership		1,490	1,490	3
4	V	19 Misc. Admin Expense		Alden of Bloomingdale Limited Partnership		196	196	4
5	V	33 Real estate taxes		Alden of Bloomingdale Limited Partnership		13,528	13,528	5
6	V	26 Insurance expense		Alden of Bloomingdale Limited Partnership		1,506	1,506	6
7	V							7
8	V	32 Interest on operating loss loan		Alden of Bloomingdale Limited Partnership		22,596	22,596	8
9	V	36 Mortgage insurnace premuim		Alden of Bloomingdale Limited Partnership		6,602	6,602	9
10	V	30 Depreciation		Alden of Bloomingdale Limited Partnership		28,497	28,497	10
11	V	31 Amortization		Alden of Bloomingdale Limited Partnership		602	602	11
12	V	32 Interest on mortgage		Alden of Bloomingdale Limited Partnership		47,431	47,431	12
13	V							13
14	Total		\$ 108,013			\$ 122,448	\$ * 14,435	14

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

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/05

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	\$ 88,747	Alden Management Services		\$ 1,661	\$ (87,086)	15
16	V	21 Clerical and G & A		Alden Management Services		3,151	3,151	16
17	V	5 Utilities		Alden Management Services		300	300	17
18	V	6 Maintenance		Alden Management Services		893	893	18
19	V	24 Travel & seminar		Alden Management Services		1,668	1,668	19
20	V	26 Insurance		Alden Management Services		25	25	20
21	V	20 Dues/subscriptions/fees etc		Alden Management Services		60	60	21
22	V	30 Depreciation		Alden Management Services		8,035	8,035	22
23	V	31 Amortization		Alden Management Services		161	161	23
24	V	33 Real estate taxes		Alden Management Services		656	656	24
25	V	35 Rent-equipment/vehicles		Alden Management Services		2,848	2,848	25
26	V	32 Interest		Alden Management Services		7,038	7,038	26
27	V	7 Salaries-general serv		Alden Management Services		4,497	4,497	27
28	V	15 Salaries-health care		Alden Management Services		2,919	2,919	28
29	V	27 Salaries-general admin		Alden Management Services		40,819	40,819	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		\$ 88,747			\$ 74,731	\$ * (14,016)	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	1 Dietary Consultant	\$	Prism Health Care		\$		15
16	V	7 Dietary Sal & Wages		Prism Health Care				16
17	V	2 Tude Feeding		Prism Health Care				17
18	V	10 Equipment Rental-patient care		Prism Health Care				18
19	V	39 Ancillary supplies	738	Prism Health Care		161	(577)	19
20	V	39 Ancillary Vent Rentals		Prism Health Care				20
21	V	27 Gen'l & Admin Salaries		Prism Health Care		46	46	21
22	V	21 Gen'l & Admin Expense		Prism Health Care		31	31	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		\$ 738			\$ 238	\$ * (500)	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	39	Drugs	\$ 256	Forum Extended Care II		\$ 364	\$ 108	15
16	V	39	I.V.		Forum Extended Care II				16
17	V	39	Wound Care	105	Forum Extended Care II		83	(22)	17
18	V	10	House Stock	346	Forum Extended Care II		306	(40)	18
19	V	10	Pharm Consult	384	Forum Extended Care II		335	(49)	19
20	V	27	Employ. Vaccin		Forum Extended Care II				20
21	V	27	G & A Salary		Forum Extended Care II		34	34	21
22	V	21	Gen'l Admin		Forum Extended Care II		29	29	22
23	V	32	Interest		Forum Extended Care II		6	6	23
24	V	33	Real Estate Tax		Forum Extended Care II		2	2	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			\$ 1,091			\$ 3,020	\$ * 1,929	39

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

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/05

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	39 Therapy	\$ 5,672	Community Physical Therapy		\$ 4,380	\$ (1,292)	15	
16	V	32 Interest		Community Physical Therapy		20	20	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		\$ 5,672			\$ 4,400	\$ *	(1,272)	39

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

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/05

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	6	Repairs & Maintenance	\$ 14,609	Alden Bennett Construction		\$ 14,952	\$ 343	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			\$ 14,609			\$ 14,952	\$ *	343 39

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

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NURSING CENTER - OLD TOWN WEST # 004-2007

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	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Northmoor	Chicago
ANC Princeton	Chicago
Alden Orland Park	Orland Park
Alden of Old Town East	Bloomington
Alden Trails	Bloomington
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 of Old Town West # 0042077 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 a.	President	President	100.00	138,796	0.2	0.50	Salary	\$ 704	27-7	1
2	Lauren Magnusson b.	Coordinator	Nursing		75,372	0.2	0.50	Salary	382	15-7	2
3	Terry Magnusson c.	Maintenance Supr	Maint.		51,240	0.2	0.50	Salary	260	7-7	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of The Alden Group, Ltd										6
7	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinaor.										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	\$ 1,346		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/05

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) 286-3743

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See Page 8A(same as 6A, also see 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 of Old Town West # 0042077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Operating Loss Loan	\$2,122.33	6/02	\$ 339,267	\$ 329,977	9/2037	6.8600	\$ 22,596	1								
2	Cambridge		X	Mortgage	\$4,506.29	9/03	873,700	858,744	8/2043	5.5000	47,431	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Related Party-AMS	X									7,038	6								
7	Related Party-FECH	X									6	7								
8	Related Party-CPT	X									20	8								
9	TOTAL Facility Related				\$6,628.62		\$ 1,212,967	\$ 1,188,721			\$ 77,091	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,188,721			\$ 77,091	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,602 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.		\$ 12,700	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.)		\$ 12,886	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 186	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 13,342	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.		\$ 13,528	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	11,779	8
	2001	12,114	9
	2002	13,304	10
	2003	12,378	11
	2004	12,886	12
<u>Accrual based on approximate 3% increase over prior year bill (\$12,886)</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:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 of Old Town West COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0042077

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>02-15-112-007</u>	<u>Nursing Home Facility</u>	\$ <u>12,886.00</u>	\$ <u>12,886.00</u>
2. <u>SEE</u>	<u>Related Party-Alden Management</u>	\$ <u>130,007.00</u>	\$ <u>656.00</u>
3. <u>ATTACHED</u>	<u>Related Party-Forum</u>	\$ <u>15,792.00</u>	\$ <u>2.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>158,685.00</u>	\$ <u>13,544.00</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 of Old Town West

0042077 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, 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>18,000</u>	<u>1995</u>	<u>\$ 150,868</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	18,000		\$ 150,868	3

Facility Name & ID Number Alden of Old Town West

0042077

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	16		1998	1998	934,861	23,372	40	23,372		152,537	5
6											6
7	Related party-Forum			1978	14,541		25			14,541	7
8											8
	Improvement Type**										
9	Sprinkler system			1999	1,510	101	15	101		696	9
10	ABC-counter tops			2004	8,102	810	10	810		2,228	10
11											11
12											12
13											13
14	ABC-Installed Dining Room Flooring			2005	5,421	151	15	151		151	14
15	ABC-Kitchen Repairs			2005	6,146	205	15	205		205	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

*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 of Old Town West

0042077

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		\$ 970,581	\$ 24,638		\$ 24,638	\$	\$ 170,358	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)		\$ 1,051,817	\$ 27,245		\$ 27,245	\$	\$ 230,498	34

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

Facility Name & ID Number Alden of Old Town West # 0042077 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	\$ 116,003	\$ 12,834	\$ 12,834	\$	Various	\$ 53,602	71
72	Current Year Purchases	9,954	904	904		Various	904	72
73	Fully Depreciated Assets	67,463	999	999		Various	67,463	73
74								74
75	TOTALS	\$ 193,420	\$ 14,737	\$ 14,737	\$		\$ 121,970	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Car Engine/Bus/Van	Various/Dodge	98-'04	\$ 8,164	\$	\$	\$	3	\$ 8,164	76
77	Related Party-AMS	Various/Bus/Autos	1998-2004	4,706	111	111		3	4,638	77
78	Bill's Auto & Truck	Truck	2003	817				1	817	78
79										79
80	TOTALS			\$ 13,687	\$ 111	\$ 111	\$		\$ 13,619	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)		\$ 1,409,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 42,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 42,093	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 366,086	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.

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/05

Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party-Cost are 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 1/1/98

Ending 6/1/06

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

Fiscal Year Ending Annual Rent

12.	<u>/2006</u>	\$ <u>37,837</u>
13.	<u>/2007</u>	\$ <u>0</u>
14.	<u>/2008</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,758 Description: Copy Machine-4758.27

(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>Various</u>	\$ <u>237.33</u>	\$ <u>2,848</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>237.33</u>	\$ <u>2,848</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 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	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	10a-3	hrs	\$		\$ 3,601	\$		\$ 3,601	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			522			522	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			1,710			1,710	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 prescrpts				364		364	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				(1,292)	243		(1,049)	13
14	TOTAL			\$		\$ 4,541	\$ 607		\$ 5,148	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.	
1. OT	10a-3	T	3,601
2. ST	10a-3	T	522
3.			
4. PT	10a-3	T	1,710
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			256
Manual Input from Related Party- Forum Drugs			108 From Pg 6C
9. Total to line 9 Pharmacy	See Pg 16A	T	364
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	T	-
12. Exceptional Care-Supplies:	See pg 16A	T	-
Total Exceptional Care (Line 12, Col 8)			-
13. Other:	See Pg 16A		-
13. Col 5: Manual Input: Related Party - CPT			(1,292) From Pg 6D
Other			843
Manual Input: Related Party - Pyramid			(576) From Pg 6B
Manual Input: Related Party FECII - I.V.			From Pg 6C
Manual Input: Related Party FECII- Wound Vac			(23) From Pg 6C
Oxygen, from reclass worksheet			From Pg 24
13. Col 6: Supplies Total		T	244
13. Total Line 13, Column 8			(1,048)
14. Total			5,148

Facility Name & ID Number Alden of Old Town West# 0042077Report 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	\$ (45,859)	\$ (44,495)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	315,037	315,037	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		218,142	5
6	Prepaid Insurance		4,491	6
7	Other Prepaid Expenses	2,521	3,621	7
8	Accounts Receivable (owners or related parties)	590,158	602,514	8
9	Other(specify): <u>Hazard Ins, real estate taxes</u>	27,732	39,666	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 889,589	\$ 1,138,976	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	24,062	24,062	15
16	Equipment, at Historical Cost	51,252	128,134	16
17	Accumulated Depreciation (book methods)	(43,155)	(257,503)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		22,407	19
	Accumulated Amortization - Organization & Pre-Operating Costs		(1,878)	20
21	Restricted Funds		30,368	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,159	\$ 1,023,940	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 921,748	\$ 2,162,916	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 55,819	\$ 55,819	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	104,365	104,365	28
29	Short-Term Notes Payable		10,044	29
30	Accrued Salaries Payable	(3,767)	(3,767)	30
	Accrued Taxes Payable (excluding real estate taxes)	2,256	2,256	31
32	Accrued Real Estate Taxes(Sch.IX-B)		13,334	32
33	Accrued Interest Payable		5,814	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Ins, exp, sales tax, and idpa</u>	1,090	1,090	36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 159,763	\$ 188,955	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	218,142	1,069,866	39
40	Mortgage Payable		326,953	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 218,142	\$ 1,396,819	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 377,905	\$ 1,585,774	46
47	TOTAL EQUITY (page 18, line 24)	\$ 543,843	\$ 577,142	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 921,748	\$ 2,162,916	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 331,653	1
2	Restatements (describe):		2
3	Prior year adjustment	(42,615)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 289,038	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	254,805	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)	\$ 254,805	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)	\$ 543,843	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/05

Ending: 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	\$ 1,267,815	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,267,815	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		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	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	Prior Year A/P Adjustment	2,265	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,265	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,270,080	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	147,021	31
32	Health Care	433,233	32
33	General Administration	229,016	33
B. Capital Expense			
34	Ownership	123,005	34
C. Ancillary Expense			
35	Special Cost Centers	6,931	35
36	Provider Participation Fee	76,069	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,015,275	40
41	Income before Income Taxes (line 30 minus line 40)**	254,805	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 254,805	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.

**Old Town West
2005**

Column 1
Amount

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.

Prior Year A/P Adjustments.

2,264.91

Total of line 28

2,264.91
=====

=====

Facility Name & ID Number Alden of Old Town West

0042077

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
2	Assistant Director of Nursing					2
3	Registered Nurses	3,951	4,199	121,789	29.00	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					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	1,680	1,832	22,824	12.46	14
15	Cook Helpers/Assistants	2,665	2,665	29,698	11.14	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,490	1,543	13,759	8.92	18
19	Laundry					19
20	Administrator	666	694	18,059	26.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,664	1,776	29,285	16.49	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,281	23,487	238,177	10.14	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	33,397	36,196	\$ 473,591 *	\$ 13.08	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		\$		35
36	Medical Director	333/Monthly	4,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32/Monthly	384	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	408	22,047	11-3	44
45	Social Service Consultant	19	1,048	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	427	\$ 27,479		49

C. CONTRACT NURSES

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

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning: 01/01/05

Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Laticia Davis	Administrative		\$ 18,059	Workers' Compensation Insurance	\$ 12,549	IDPH License Fee	\$	
				Unemployment Compensation Insurance	1,590	Advertising: Employee Recruitment	142	
				FICA Taxes	51,403	Health Care Worker Background Check	120	
				Employee Health Insurance	14,209	(Indicate # of checks performed 12)		
				Employee Meals	2,228	Surety bond Fees	350	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA dues	914	
				Life and dental Insurance/Pension	(1,086)	Secretary of State	100	
				Miscellaneous Payroll Costs	182	Related Party-AMS	60	
				Employee Drugs Test	293			
				401K Match	257	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 18,059	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Auto and Gasoline	1,165
							Vehicle Licenses/Fees	1,429
							Related Party-AMS	1,668
							Seminar Expense	
							Ill Health Care Assoc (convention/rgst))	366
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 4,628
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 95,092					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden of Old Town West

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 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	Painting	10/03	\$ 2,065	3	\$ 0	\$ 172	\$ 688	\$ 688	\$ 516	\$	\$	\$	
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,065		\$	\$ 172	\$ 688	\$ 688	\$ 516	\$	\$	\$	

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA dues: 914
- (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? 15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,345 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. \$ 76,069
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. \$ 2,228 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? 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, LLP 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 available
- (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.