



Facility Name & ID Number Alden Des Plaines Rehab & HC

# 0042010 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	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		5,755	18,953	24,708	8
9	SNF/PED					9
10	ICF	736	827		1,563	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	736	6,582	18,953	26,271	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.43%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
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 10/31/2000

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/31/2000 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 110 and days of care provided 18,953

Medicare Intermediary Adminastar Federal, Inc

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	514,369	32,483	6,855	553,707	943	554,650	(4,523)	550,127		1
2	Food Purchase		207,243		207,243	(18,656)	188,587	515	189,102		2
3	Housekeeping	139,932	25,574		165,506	799	166,305		166,305		3
4	Laundry	33,704	14,998		48,702	50	48,752		48,752		4
5	Heat and Other Utilities			199,899	199,899		199,899	(22,477)	177,422		5
6	Maintenance	40,312		111,964	152,276	137	152,413	44,837	197,250		6
7	Other (specify):* Security/Related party salary			150	150		150	22,904	23,054		7
8	<b>TOTAL General Services</b>	728,317	280,298	318,868	1,327,483	(16,727)	1,310,756	41,256	1,352,012		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			59,400	59,400		59,400		59,400		9
10	Nursing and Medical Records	2,008,329	157,482	100,868	2,266,679	10,703	2,277,382	(2,567)	2,274,815		10
10a	Therapy	54,719			54,719		54,719		54,719		10a
11	Activities	89,102	2,154	3,628	94,884	108	94,992		94,992		11
12	Social Services	42,553			42,553		42,553		42,553		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related party salary							17,335	17,335		15
16	<b>TOTAL Health Care and Programs</b>	2,194,703	159,636	163,896	2,518,235	10,811	2,529,046	14,768	2,543,814		16
	<b>C. General Administration</b>										
17	Administrative	59,501			59,501		59,501		59,501		17
18	Directors Fees										18
19	Professional Services			842,823	842,823	(21,885)	820,938	(776,790)	44,148		19
20	Dues, Fees, Subscriptions & Promotions			80,495	80,495	(259)	80,236	(66,421)	13,815		20
21	Clerical & General Office Expenses	276,395	21,427	61,646	359,468	613	360,081	(73,346)	286,735		21
22	Employee Benefits & Payroll Taxes			465,846	465,846	11,140	476,986	(21,261)	455,725		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,891	5,891		5,891	896	6,787		24
25	Other Admin. Staff Transportation							4,863	4,863		25
26	Insurance-Prop.Liab.Malpractice			116,394	116,394	16,307	132,701	11,402	144,103		26
27	Other (specify):* Bad debt/Related party salary			118,193	118,193		118,193	123,017	241,210		27
28	<b>TOTAL General Administration</b>	335,896	21,427	1,691,288	2,048,611	5,916	2,054,527	(797,640)	1,256,887		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,258,916	461,361	2,174,052	5,894,329		5,894,329	(741,616)	5,152,713		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 &amp; ID Number

Alden Des Plaines Rehab &amp; HC

#0042010

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			52,341	52,341		52,341	227,055	279,396			30
31	Amortization of Pre-Op. & Org.							1,338	1,338			31
32	Interest			289,455	289,455		289,455	329,241	618,696			32
33	Real Estate Taxes							304,789	304,789			33
34	Rent-Facility & Grounds			1,174,116	1,174,116		1,174,116	(1,174,116)				34
35	Rent-Equipment & Vehicles			10,326	10,326		10,326	17,499	27,825			35
36	Other (specify):* MIP & Amortiz.							52,341	52,341			36
37	<b>TOTAL Ownership</b>			1,526,238	1,526,238		1,526,238	(241,853)	1,284,385			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		978,292	1,339,215	2,317,507		2,317,507	(238,389)	2,079,118			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		978,292	1,399,440	2,377,732		2,377,732	(238,389)	2,139,343			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,258,916	1,439,653	5,099,730	9,798,299		9,798,299	(1,221,858)	8,576,441			45

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

IDPH Facility Number #42010  
 Reporting Period Beginning 1/01/06  
 Reporting Period Ending 12/31/06

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2	22	(18,656)	Employee Meal
		18,656	Employee Meal
22		(7,516)	Uniforms
	1	943	Uniforms
	3	799	Uniforms
	4	50	Uniforms
	6	137	Uniforms
	10	5,125	Uniforms
	11	108	Uniforms
	21	354	Uniforms
20	21	(259)	Extended Care Info Network
		259	Extended Care Info Network
19	26	(16,307)	"Legion" Insurance Exp-Kloss
		16,307	"Legion" Insurance Exp-Kloss
19	10	(5,578)	Pathway-Clinical consultant
		5,578	Pathway-Clinical consultant
		<u>0</u>	Net should be 0

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	(90,935)	30		9
10	Interest and Other Investment Income	(503)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,486)	2		13
14	Non-Care Related Interest	(11,346)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,563)	21		17
18	Fines and Penalties	(12,378)	32		18
19	Entertainment	(588)	20		19
20	Contributions	(6,108)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,934)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(118,193)	27		24
25	Fund Raising, Advertising and Promotional	(59,118)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (317,152)</b>		<b>\$</b>	<b>30</b>

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)	(508,730)	Various	34
35	Other- Attach Schedule See Pg 5A	(395,976)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (904,706)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,221,858)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

BHF USE ONLY					
48		49		50	
				51	
					52

Alden Des Plaines Rehab &amp; HC

ID# 0042010

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late fees on utilities	\$ (6,794)	5	1
2	Late fees on telephone (gl 6843)	(380)	21	2
3				3
4	Intercompany (AMS) interest (gl 7031)	(81,721)	32	4
5	Intercompany (AMS) interest (gl 7053)	(530)	32	5
6	Misc income - records (gl 4977-100-001)	(1,015)	10	6
7	Misc income - jury duty (gl 4977-100-002)	(17)	21	7
8	Misc income - wage service (gl 4977-100-006)	(78)	21	8
9	Marketing Mgr (g/l 6701-100-009)	(146,665)	21	9
10	Mktg Mgr employee benefits reduction	(21,261)	22	10
11	IL Health Care Assoc PAC dues (30.65%)	(1,649)	20	11
12	Add vendor settlement cost (gl 7143) to reclass	17,073	21	12
13	Back out vendor settlement credit (gl 7143)(ComEd)	(17,073)	5	13
14	Back out legal fees for collections	(800)	19	14
15	Back out LLC mtge int > CON asset limit	(152,659)	32	15
16	Back out LLC MIP exp > CON asset limit	(18,247)	36	16
17	Back out LLC bank charges	(125)	21	17
18				18
19	Adj deferred maintenance exp to equal page 22's	(306)	6	19
20				20
21	Expense assets < \$2,500	1,467	6	21
22	Back out depreciation on assets < \$2,500	(82)	30	22
23	Expense assets < \$2,500	40,055	6	23
24	Back out depreciation on assets < \$2,500	(4,841)	30	24
25	Adjust depreciation to Pg 13's	(328)	30	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(395,976)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Des Plaines Rehab &amp; HC

# 0042010

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
<b>1</b>	<b>A. General Services</b>													
1	Dietary	0	0	0	(4,523)	0	0	0	0	0	0	0	(4,523)	1
2	Food Purchase	(1,486)	0	0	2,001	0	0	0	0	0	0	0	515	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	(23,867)	0	1,390	0	0	0	0	0	0	0	0	(22,477)	5
6	Maintenance	41,216	0	3,849	0	0	0	(228)	0	0	0	0	44,837	6
7	Other (specify):*	0	0	19,821	3,083	0	0	0	0	0	0	0	22,904	7
8	<b>TOTAL General Services</b>	<b>15,863</b>	<b>0</b>	<b>25,060</b>	<b>561</b>	<b>0</b>	<b>0</b>	<b>(228)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>41,256</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,015)	0	0	398	(1,950)	0	0	0	0	0	0	(2,567)	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	17,335	0	0	0	0	0	0	0	0	17,335	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,015)</b>	<b>0</b>	<b>17,335</b>	<b>398</b>	<b>(1,950)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>14,768</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,734)	4,500	(765,556)	0	0	0	0	0	0	0	0	(776,790)	19
20	Fees, Subscriptions & Promotions	(67,463)	0	1,042	0	0	0	0	0	0	0	0	(66,421)	20
21	Clerical & General Office Expenses	(131,755)	2,785	15,412	13,396	26,816	0	0	0	0	0	0	(73,346)	21
22	Employee Benefits & Payroll Taxes	(21,261)	0	0	0	0	0	0	0	0	0	0	(21,261)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	896	0	0	0	0	0	0	0	0	896	24
25	Other Admin. Staff Transportation	0	0	4,863	0	0	0	0	0	0	0	0	4,863	25
26	Insurance-Prop.Liab.Malpractice	0	11,288	114	0	0	0	0	0	0	0	0	11,402	26
27	Other (specify):*	(118,193)	0	194,406	17,306	29,498	0	0	0	0	0	0	123,017	27
28	<b>TOTAL General Administration</b>	<b>(354,406)</b>	<b>18,573</b>	<b>(548,823)</b>	<b>30,702</b>	<b>56,314</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(797,640)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(339,558)</b>	<b>18,573</b>	<b>(506,428)</b>	<b>31,661</b>	<b>54,364</b>	<b>0</b>	<b>(228)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(741,616)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Des Plaines Rehab &amp; HC

# 0042010

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(96,186)	316,105	5,278	0	1,858	0	0	0	0	0	0	227,055	30
31	Amortization of Pre-Op. & Org.	0	0	1,338	0	0	0	0	0	0	0	0	1,338	31
32	Interest	(259,137)	536,733	44,772	0	3,600	3,273	0	0	0	0	0	329,241	32
33	Real Estate Taxes	0	300,351	3,094	0	1,344	0	0	0	0	0	0	304,789	33
34	Rent-Facility & Grounds	0	(1,174,116)	0	0	0	0	0	0	0	0	0	(1,174,116)	34
35	Rent-Equipment & Vehicles	0	0	17,499	0	0	0	0	0	0	0	0	17,499	35
36	Other (specify):*	(18,247)	70,588	0	0	0	0	0	0	0	0	0	52,341	36
37	<b>TOTAL Ownership</b>	<b>(373,570)</b>	<b>49,661</b>	<b>71,981</b>	<b>0</b>	<b>6,802</b>	<b>3,273</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(241,853)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(200,354)	(159,359)	121,324	0	0	0	0	0	(238,389)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(200,354)</b>	<b>(159,359)</b>	<b>121,324</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(238,389)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(713,128)</b>	<b>68,234</b>	<b>(434,447)</b>	<b>(168,693)</b>	<b>(98,193)</b>	<b>124,597</b>	<b>(228)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,221,858)</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6L		See PG6K		See PG6K		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,174,116	Alden-Des Plaines Rehab and Health Care Center, LLC		\$	\$ (1,174,116)	1
2	V	32 Interest-Replacement reserve	3,506	Alden-Des Plaines Rehab and Health Care Center, LLC			(3,506)	2
3	V	32 Interest - facility loan	69,678	Alden-Des Plaines Rehab and Health Care Center, LLC			(69,678)	3
4	V	19 Accounting/Prof Fees		Alden-Des Plaines Rehab and Health Care Center, LLC		4,500	4,500	4
5	V	21 Bank charges		Alden-Des Plaines Rehab and Health Care Center, LLC		125	125	5
6	V	21 Licenses, etc		Alden-Des Plaines Rehab and Health Care Center, LLC		2,660	2,660	6
7	V	33 Real estate taxes		Alden-Des Plaines Rehab and Health Care Center, LLC		300,351	300,351	7
8	V	26 Property & liability ins		Alden-Des Plaines Rehab and Health Care Center, LLC		11,288	11,288	8
9	V	36 Mortgage insurance		Alden-Des Plaines Rehab and Health Care Center, LLC		65,169	65,169	9
10	V	32 Interest on mortgage		Alden-Des Plaines Rehab and Health Care Center, LLC		525,663	525,663	10
11	V	32 Interest on IOD loan		Alden-Des Plaines Rehab and Health Care Center, LLC		84,254	84,254	11
12	V	30 Depreciation		Alden-Des Plaines Rehab and Health Care Center, LLC		316,105	316,105	12
13	V	36 Amortization		Alden-Des Plaines Rehab and Health Care Center, LLC		5,419	5,419	13
14	Total		\$ 1,247,300			\$ 1,315,534	\$ * 68,234	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional fees	\$ 777,421	Alden Management Services, Inc.		\$ 11,865	\$ (765,556)
16	V	21 Clerical and G & A		Alden Management Services, Inc.		15,412	15,412
17	V	5 Utilities		Alden Management Services, Inc.		1,390	1,390
18	V	6 Maintenance		Alden Management Services, Inc.		3,849	3,849
19	V	24 Travel & seminar		Alden Management Services, Inc.		896	896
20	V	25 Other admin travel		Alden Management Services, Inc.		4,863	4,863
21	V	26 Insurance		Alden Management Services, Inc.		114	114
22	V	20 Dues/subscriptions/fees etc		Alden Management Services, Inc.		1,042	1,042
23	V	30 Depreciation		Alden Management Services, Inc.		5,278	5,278
24	V	31 Amortization		Alden Management Services, Inc.		1,338	1,338
25	V	33 Real estate taxes		Alden Management Services, Inc.		3,094	3,094
26	V	35 Rent-equipment/vehicles		Alden Management Services, Inc.		17,499	17,499
27	V	32 Interest		Alden Management Services, Inc.		44,772	44,772
28	V	7 Salaries-general serv		Alden Management Services, Inc.		19,821	19,821
29	V	15 Salaries-health care		Alden Management Services, Inc.		17,335	17,335
30	V	27 Salaries-general admin		Alden Management Services, Inc.		194,406	194,406
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 777,421			\$ 342,974	\$ * (434,447)

\* 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	\$ 6,855	Prism Health Care Services, Inc.		\$ 2,332	\$ (4,523)
16	V	7 Dietary salaries		Prism Health Care Services, Inc.		3,083	3,083
17	V	2 Tube feeding	1,738	Prism Health Care Services, Inc.		3,739	2,001
18	V	10 Equipment rental-patient care	3,060	Prism Health Care Services, Inc.		3,458	398
19	V	39 Ancillary supplies	249,742	Prism Health Care Services, Inc.		49,388	(200,354)
20	V	27 G & A salaries		Prism Health Care Services, Inc.		17,306	17,306
21	V	21 G & A expenses		Prism Health Care Services, Inc.		13,396	13,396
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 261,395			\$ 92,702	\$ * (168,693)

\* 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	\$ 379,233	Forum Extended Care Services II, Inc.		\$ 532,463	\$ 153,230
16	V	39 I.V.	348,480	Forum Extended Care Services II, Inc.		36,074	(312,406)
17	V	39 Wound Vac	838	Forum Extended Care Services II, Inc.		655	(183)
18	V	10 House Stock	12,069	Forum Extended Care Services II, Inc.		10,880	(1,189)
19	V	10 Pharm Consult	6,430	Forum Extended Care Services II, Inc.		5,669	(761)
20	V	27 Employ Vaccin	1,728	Forum Extended Care Services II, Inc.		1,351	(377)
21	V	27 G & A Salaries		Forum Extended Care Services II, Inc.		29,875	29,875
22	V	21 Gen'l & Admin		Forum Extended Care Services II, Inc.		26,816	26,816
23	V	32 Interest		Forum Extended Care Services II, Inc.		3,600	3,600
24	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		1,344	1,344
25	V	30 Depreciation		Forum Extended Care Services II, Inc.		1,858	1,858
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 748,778			\$ 650,585	\$ * (98,193)

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Revenue - therapy	\$ 1,275,081	Community Physical Therapy & Associates, Ltd.		\$ 1,396,405	\$ 121,324	15
16	V	32 Interest		Community Physical Therapy & Associates, Ltd.		3,273	3,273	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	<b>Total</b>		\$ 1,275,081			\$ 1,399,678	\$ * 124,597	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Repairs & maintenance	\$ 14,924	Alden Bennett Construction Company, Inc.		\$ 14,696	\$ (228)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 14,924			\$ 14,696	\$ * (228)

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

Facility Name & ID Number Alden Nursing Center - Des Plaines

42010

Report Period Beginning 01/01/06

Ending: 12/31/06

Note: ANC = Alden Nursing Center

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

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

IDPH Facility Number

#42010

Reporting Period Beginning

1/01/06

Reporting Period Ending

12/31/06

**Investor List**

FLOYD A. SCHLOSSBERG	37
JOAN/SAM CARL	9
AMI PISSETZKY	1
LAUREN & TERRY MAGNUSSION	1
Others	52
TOTALS	<hr/> 100

Facility Name &amp; ID Number

Alden Des Plaines Rehab &amp; HC

# 0042010

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	37.00	136,223	0.94	2.35	salary	\$ 3,277	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.50	79,844	0.94	2.35	salary	1,921	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.50	51,799	0.94	2.35	salary	1,246	7-7	3
4	Joan Carl d.	Secretary	Vice-President	9.00	136,223	0.94	2.35	salary	3,277	27-7	4
5	Ami Pissetzky e.	Financial Service	Invest/Banking	1.00	136,223	0.94	2.35	salary	3,277	27-7	5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12	e. Ami Pissetzky is the Director of Finance. He has an interest in the real estate of Des Plaines.										12
13								TOTAL	\$ 12,998		13

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

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

Facility Name & ID Number Alden Des Plaines Rehab & HC

# 0042010 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 (also on Page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name &amp; ID Number

Alden Des Plaines Rehab &amp; HC

# 0042010

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	Name of Lender	2		3	4	5	6		7	8	9	10
		Related**					Purpose of Loan	Monthly Payment Required				
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	Cambridge Realty		X	Mortgage	\$53,475.00	9/1/2005	\$ 10,390,300	\$ 10,293,439	4/1/2044	5.4000	\$ 525,663	1
2	Cambridge Realty		X	Operating loss loan	\$8,538.00	3/1/2004	1,690,000	1,643,654	6/1/2040	5.1000	84,254	2
3				Int exp in excess of CON cap							(152,659)	3
4	Bank Leumi		X	Working capital	varies	3/29/2006	1,500,000	1,484,000	6/1/2007	varies	113,803	4
5												5
<b>Working Capital</b>												
6	Related party-AMS	X		Working capital							44,772	6
7	Related party-FECSII	X		Working capital							3,600	7
8	Related party-CPT	X		Working capital							3,273	8
9	TOTAL Facility Related				\$62,013.00		\$ 13,580,300	\$ 13,421,093			\$ 622,706	9
<b>B. Non-Facility Related*</b>												
10	DP Rehab & HCC, LCC	X		Interest-Replacement Res							(3,507)	10
11	Patient interest income		X	Non-care interest income							(503)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (4,010)	14
15	TOTALS (line 9+line14)						\$ 13,580,300	\$ 13,421,093			\$ 618,696	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 46,922      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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	<b>284,200</b>	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.)		\$	<b>287,951</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,751</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>296,600</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>300,351</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<b>112,958</b>	8
	2002	<b>261,776</b>	9
	2003	<b>269,644</b>	10
	2004	<b>275,910</b>	11
	2005	<b>287,951</b>	12

**Accrual based on 3% increase over prior year bills.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden Des Plaines Rehab & HC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042010

CONTACT PERSON REGARDING THIS REPORT Steven M Kroll

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

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>09-17-200-128-0000</u>	<u>Nursing home facility</u>	\$ <u>169,423.36</u>	\$ <u>169,423.36</u>
2. <u>09-17-200-129-000</u>	<u>Nursing home facility</u>	\$ <u>118,527.16</u>	\$ <u>118,527.16</u>
3. <u>See Attached</u>	<u>Related Party-Alden Mgmt Serv</u>	\$ <u>131,720.00</u>	\$ <u>3,094.00</u>
4. <u>See Attached</u>	<u>Related Party-FECII</u>	\$ <u>14,554.00</u>	\$ <u>1,344.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>434,224.52</u>	\$ <u>292,388.52</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Alden Des Plaines Rehab & HC

# 0042010

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 51,490 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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).

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	110	2000	2000	9,685,956	242,149	40	174,652	(67,497)	\$ 1,159,882
5	Adjustment to correct to CON costs (net=6,986,060)			(2,699,896)					
6									
7									
8	Related party - FECSII		1978	14,839		25			14,839
	Improvement Type**								
9	ISS/Chicago Sound & Communication(vent alarm interface)		2000	3,400	340	10	340		2,267
10	Alden Bennett Construction(multiple wireless install)		2001	4,894	489	10	489		2,773
11	Owners extras (change orders)		2000	524,876	26,244	20	26,244		168,398
12	Owners extras (change orders)		2000	12,972	648	20	648		4,162
13	ABC-parking lot sealcoat/stripe		2002	3,852	550	7	550		2,431
14	ABC-screened patio enclosure		2002	10,069	1,438	7	1,438		6,952
15	EWS Welding-alarm		2002	1,076	108	10	108		538
16	New Horizons-residents phones		2002	1,646	165	10	165		768
17	New Horizons-residents phones		2002	3,161	316	10	316		1,449
18	ABC-owners extras		2003	2,571	171	15	171		685
19	ABC-owners extras		2003	5,511	367	15	367		1,469
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	ABC [GT Mechanical]-Replace B1 compressor		2006	4,889	407	10	407		407
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 7,579,816	\$ 273,392		\$ 205,895	\$ (67,497)	\$ 1,367,020	1
2									2
3	<b>Related Party-Forum Prof Center Building:</b>								3
4	Leasehold Improvement-Remodeling	1980	11,260		15			11,260	4
5	Leasehold Improvement-Remodeling	1980	17,639		20			17,639	5
6	Leasehold Improvement-Tenant Improvement	1987	912		13			912	6
7	Leasehold Improvement-AMS Remodel	1988	14,634		10			14,634	7
8	Leasehold Improvement-Roof	1994	3,269	204	16	204		2,453	8
9	Leasehold Improvement-Build.Improv.	1996	1,153	72	16	72		789	9
10	Leasehold Improvement-Asphalting	2000	89		3			89	10
11	Leasehold Improvement-DAI	2001	157	16	10	16		81	11
12	Leasehold Improvement-Bathrooms	2002	681	77	7	77		324	12
13	Leasehold Improvement-Suite Renovation	2003	1,672	167	10	167		669	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	2,071	360	7	360		835	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	73		23			73	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	126	6	5	6		126	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	<b>Related Party-AMS:</b>								26
27	Leasehold Improvement-Remodeling	1993	6,060		7			6,060	27
28	Leasehold Improvement-Remodeling	2002	4,961	709	7	709		2,746	28
29	Leasehold Improvement-Remodeling	2003	5,189	741	7	741		2,856	29
30									30
31									31
32									32
33	<b>Forum Extended Care, LLC-building/building improv</b>	1999	12,434	293	30	293		2,350	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,662,195	\$ 276,037		\$ 208,540	\$ (67,497)	\$ 1,430,916	34

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

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	\$ 674,869	\$ 91,944	\$ 68,506	\$ (23,438)	Various	\$ 405,839	71
72	Current Year Purchases	9,354	758	758		Various	758	72
73	Fully Depreciated Assets	68,783	1,479	1,479		Various	68,783	73
74								74
75	TOTALS	\$ 753,006	\$ 94,181	\$ 70,743	\$ (23,438)		\$ 475,380	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus	2001	2001	\$ 49,826	\$	\$	\$	5	\$ 49,826	76
77	AMS-Bus/Travel Van	Chev/Lumina/'00/Various	98-'04	4,817	113	113		3	4,787	77
78										78
79										79
80	TOTALS			\$ 54,643	\$ 113	\$ 113	\$		\$ 54,613	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,485,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 370,331	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 279,396	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (90,935)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,960,909	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 10,327 Description: Copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related party - AMS</u>		\$ <u>#####</u>	\$ <u>17,499</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>17,499</u>	21

10. Effective dates of current rental agreement:

Beginning 7/1/2001

Ending 7/1/2008

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 1670k

13. /2008 \$ 835k

14. /2009 \$ \_\_\_\_\_

\* 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 Nursing 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

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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	\$		\$ 471,378	\$		\$ 471,378	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,753			21,753	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			781,266			781,266	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 16A	# of prescripts				532,463		532,463	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 16A				121,324	150,934		272,258	13
14	TOTAL			\$		\$ 1,395,721	\$ 683,397		\$ 2,079,118	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	39-3	To Col 5	\$471,377.77
2. ST	39-3	To Col 5	21,752.88
3.			
4. PT	39-3	To Col 5	781,266.35
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			379,232.69
Manual Input from Related Party- FECSII Drugs			153,231.00 see pg 6C
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	----- 532,463.69 -----
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	121,324.00 see pg 6D
Other			663,877.02
Manual Input: Related Party - Prism			(200,354.00) see pg 6B
Manual Input: Related Party FECSII - I.V.			(312,406.00) see pg 6C
Manual Input: Related Party FECSII - Wound Care			(183.00) see pg 6C
Oxygen, from reclass worksheet			0.00
13. Col 6: Supplies Total		To Col 6	----- 150,934.02 -----
13. Total Line 13, Column 8			----- 0.00 -----
14. Total			----- 2,079,118.71 =====

Facility Name &amp; ID Number Alden Des Plaines Rehab &amp; HC

# 0042010

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>136,000</u> )	1,195,339	1,195,339	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		149,467	5
6	Prepaid Insurance		59,730	6
7	Other Prepaid Expenses	5,087	5,087	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	42,125	42,125	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,242,551	\$ 1,451,748	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,003,985	13
14	Buildings, at Historical Cost		9,685,956	14
15	Leasehold Improvements, at Historical Cost	583,448	583,448	15
16	Equipment, at Historical Cost	264,238	1,337,729	16
17	Accumulated Depreciation (book methods)	(340,310)	(2,318,143)	17
18	Deferred Charges	324,417	324,417	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		626,058	21
22	Other Long-Term Assets (specify): <u>Due from affiliates</u>	2,715,188	5,301,148	22
23	Other(specify): <u>Refinancing fees</u>		209,976	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 3,546,981	\$ 16,754,574	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,789,532	\$ 18,206,322	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 803,318	\$ 809,044	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	138,858	138,858	28
29	Short-Term Notes Payable	1,573,797	1,573,797	29
30	Accrued Salaries Payable	353,867	353,867	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,951	16,951	31
32	Accrued Real Estate Taxes(Sch.IX-B)		296,600	32
33	Accrued Interest Payable	16,959	70,265	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued exp, ins,sales tax, etc</u>	20,454	34,186	36
37	<u>Due to affiliates/Deferred revenue</u>	1,819,687	2,263,155	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 4,743,891	\$ 5,556,723	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,937,093	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 11,937,093	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,743,891	\$ 17,493,816	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 45,641	\$ 712,506	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,789,532	\$ 18,206,322	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (667,864)	1
2	Restatements (describe):		2
3	Adjs made after 2005 rpt submitted; no effect on 2005 rpt		3
4	Income tax adjustment	124,417	4
5	External audit adj	(2,022)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (545,469)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	591,110	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)	\$ 591,110	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 45,641	24 *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 10,330,585	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,330,585	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	16,945	6
7	Oxygen	3,814	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 20,759	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	33	12
13	Barber and Beauty Care	1,352	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,244	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	23,027	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 28,656	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	503	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 503	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached PG19A</u>	1,110	28
28a	<u>Gain on sale of assets</u>	7,796	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,906	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,389,409	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,327,483	31
32	Health Care	2,518,235	32
33	General Administration	2,048,611	33
	<b>B. Capital Expense</b>		
34	Ownership	1,526,238	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	2,317,507	35
36	Provider Participation Fee	60,225	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,798,299	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	591,110	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 591,110	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 due If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

IDPH Facility Number #42010  
Reporting Period Beginning 1/01/06  
Reporting Period Ending 12/31/06

<u>Misc Income (G/L 4977)</u>		<u>Ref Line</u>
Record copies (g/l 4977-100-001)	1,015.25	10
Wage service fee (g/l 4977-100-006)	78.00	21
Jury duty (g/l 4977-100-023)	17.20	21
Total G/L 4977	<u>1,110.45</u>	
Total of Page 19, Line 28	<u><u>1,110.45</u></u>	

Facility Name & ID Number Alden Des Plaines Rehab & HC

# 0042010

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	507	523	\$ 18,689	\$ 35.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,526	26,963	835,924	31.00	3
4	Licensed Practical Nurses	10,440	11,044	279,846	25.34	4
5	CNAs & Orderlies	54,476	59,118	765,350	12.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,967	2,211	34,736	15.71	8
9	Activity Director	1,296	1,415	29,268	20.68	9
10	Activity Assistants	5,566	5,899	59,835	10.14	10
11	Social Service Workers	1,976	2,080	42,553	20.46	11
12	Dietician					12
13	Food Service Supervisor	2,848	3,010	73,128	24.30	13
14	Head Cook	2,797	2,968	41,751	14.07	14
15	Cook Helpers/Assistants	36,264	39,231	399,491	10.18	15
16	Dishwashers					16
17	Maintenance Workers	1,760	1,909	40,312	21.12	17
18	Housekeepers	14,208	14,946	139,932	9.36	18
19	Laundry	3,107	3,426	33,704	9.84	19
20	Administrator	2,064	2,080	59,501	28.61	20
21	Assistant Administrator					21
22	Other Administrative	7,678	7,958	239,055	30.04	22
23	Office Manager	1,976	2,080	30,393	14.61	23
24	Clerical	3,125	3,221	26,930	8.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,359	2,463	76,322	30.99	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Unit Director	1,960	2,080	32,196	15.48	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,900	194,625	\$ 3,258,916 *	\$ 16.74	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 6,855	1-3	35
36	Medical Director	Monthly	65,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,640	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	9	503	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	\$ 75,398		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Margo Martinez	Administrator		\$ 59,501	Workers' Compensation Insurance	\$ 78,630	IDPH License Fee	\$	
				Unemployment Compensation Insurance	42,009	Advertising: Employee Recruitment	91	
				FICA Taxes	240,417	Health Care Worker Background Check	580	
				Employee Health Insurance	25,809	(Indicate # of checks performed 58 )		
				Employee Meals	18,656	Patient Background Checks	5,180	
				Illinois Municipal Retirement Fund (IMRF)*		Surety bond fees	100	
				Union health & welfare	47,095	Subscriptions	119	
				Union pension	24,549	Alliance for Qual Nursing	1,650	
				Dental/Life/401k match	2,108	IL Health Care Assoc	5,053	
				Empl rel/Misc pr	1,515	Related party - AMS	1,042	
				EE drug tests/Vaccinations	2,812	Less: Public Relations Expense	( )	
				Mktg Mgr employee benefit deduction	(21,261)	Non-allowable advertising	( )	
				Gardens/Crts administrator e/b deduction	(6,614)	Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,501	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
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	
							Gas,insurance,license,repairs	2,863
							Related party - AMS	896
							Seminar Expense	
							Leadership training	1,570
							IHCA-Medicaid/Family Alliance	826
							Amer Diet/ServSafe Cert/Alz Assoc/RN	632
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
C. Professional Services								
Vendor/Payee	Type		Amount					
Alden Mgmt Services	Management fees		\$ 777,421					
BDO Seidman	Accounting fees		10,671					
Kenneth Fisch	Legal fees:collections		14,934					
Kenneth Fisch	Legal fees:non-collections		12,690					
Estate of Jean Kloss	Legal fees:non-collections		16,307					
Barry Greenburg	Legal fees:non-collections		525					
Pathway	Clinical consultant		5,578					
SMS	Billing consultant		3,021					
Medicom/KPMG	Consulting:billing/fs		323					
Daley/Condon Grp/Dana	Consulting:billing/fs/401k		418					
Edward Malloy Assoc	Appraisal survey		935					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 842,823					

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	HVAC compressor	1/2002	\$ 3,063	3	\$ 1,021	\$ 1,021	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,063		\$ 1,021	\$ 1,021	\$	\$	\$	\$	\$	\$								

Facility Name &amp; ID Number Alden Des Plaines Rehab &amp; HC

# 0042010

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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. II. Health Care Assn. \$5,053
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,491 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,225  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,656 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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
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? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Audit not required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees