

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0017319

Facility Name: ALDEN LAKELAND REHAB & HCC

Address: 820 WEST LAWRENCE CHICAGO 60640
 Number City Zip Code

County: COOK

Telephone Number: (773) 769-2570 **Fax #** (773) 769-1551

HFS ID Number: 36-2687662

Date of Initial License for Current Owners: 01/01/72

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 01/01/06 to 12/31/06 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>CFO</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 LAKELAND REHAB & HCC# 0017319 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	300	Skilled (SNF)	300	109,500	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	300	TOTALS	300	109,500	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	13,777	3,189	5,414	22,380	8
9	SNF/PED					9
10	ICF	43,608	903	0	44,511	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,385	4,092	5,414	66,891	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.09%

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

0 (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)F. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

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

YES NO

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

Date started 1/1/72

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

YES Date _____ NO

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

YES NO If YES, enter number
of beds certified 187 and days of care provided 4,646Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL 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 LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	277,627	31,818	9,600	319,045	919	319,964	(6,334)	313,630		1
2	Food Purchase		444,870		444,870	(27,835)	417,035	(78,321)	338,714		2
3	Housekeeping	255,023	42,158		297,181	788	297,969		297,969		3
4	Laundry	89,035	26,192		115,227	138	115,365		115,365		4
5	Heat and Other Utilities			333,491	333,491		333,491	(10,555)	322,936		5
6	Maintenance	46,049		186,709	232,758	37	232,795	35,085	267,880		6
7	Other (specify):* Related Party Salary/	43,672			43,672		43,672	54,786	98,458		7
8	TOTAL General Services	711,406	545,038	529,800	1,786,244	(25,953)	1,760,291	(5,339)	1,754,952		8
	B. Health Care and Programs										
9	Medical Director			51,987	51,987		51,987		51,987		9
10	Nursing and Medical Records	3,135,752	294,326	27,510	3,457,588	(138,166)	3,319,422	(2,075)	3,317,347		10
10a	Therapy	93,072			93,072		93,072		93,072		10a
11	Activities	143,730	3,391	3,269	150,390	230	150,620		150,620		11
12	Social Services	42,092			42,092		42,092		42,092		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Salary							44,137	44,137		15
16	TOTAL Health Care and Programs	3,414,646	297,717	82,766	3,795,129	(137,936)	3,657,193	42,062	3,699,255		16
	C. General Administration										
17	Administrative	173,911			173,911		173,911		173,911		17
18	Directors Fees										18
19	Professional Services			969,771	969,771	(2,720)	967,051	(858,492)	108,559		19
20	Dues, Fees, Subscriptions & Promotions			77,927	77,927	2,720	80,647	(47,340)	33,307		20
21	Clerical & General Office Expenses	125,358	26,438	91,298	243,094	408	243,502	47,268	290,770		21
22	Employee Benefits & Payroll Taxes			763,814	763,814	18,797	782,611	(3,896)	778,715		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,308	5,308		5,308	2,280	7,588		24
25	Other Admin. Staff Transportation							12,383	12,383		25
26	Insurance-Prop.Liab.Malpractice			315,540	315,540		315,540	11,428	326,968		26
27	Other (specify):* Related Party Salary/ Bad Debt			128,374	128,374		128,374	407,254	535,628		27
28	TOTAL General Administration	299,269	26,438	2,352,032	2,677,739	19,205	2,696,944	(429,115)	2,267,829		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,425,321	869,193	2,964,598	8,259,112	(144,684)	8,114,428	(392,392)	7,722,036		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 LAKELAND REHAB & HCC #0017319 Report Period Beginning: 01/01/06 Ending: 12/31/06

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			102,098	102,098		102,098	469,268	571,366			30
31	Amortization of Pre-Op. & Org.							5,056	5,056			31
32	Interest			172,729	172,729		172,729	661,192	833,921			32
33	Real Estate Taxes							239,861	239,861			33
34	Rent-Facility & Grounds			1,212,354	1,212,354		1,212,354	(1,212,354)				34
35	Rent-Equipment & Vehicles			8,250	8,250		8,250	47,478	55,728			35
36	Other (specify):* MIP & Amortiz.							58,366	58,366			36
37	TOTAL Ownership			1,495,431	1,495,431		1,495,431	268,867	1,764,298			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	835,350	681,607	683,714	2,200,671	144,684	2,345,355	(211,940)	2,133,415			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		39		39		39	(39)				41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	835,350	681,646	847,964	2,364,960	144,684	2,509,644	(211,979)	2,297,665			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,260,671	1,550,839	5,307,993	12,119,503		12,119,503	(335,504)	11,783,999			45

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

Alden Nursing Center Lakeland #17319
 Reporting Period Beginning 1/1/2006
 Reporting Period Ending 12/31/2006

Reclassifications Pgs 3 and 4

From Line	To Line	Amount	Description
22		(9,038.00)	Uniform
	1	919.00	Uniform
	3	788.00	Uniform
	4	138.00	Uniform
	6	37.00	Uniform
	10	6,518.00	Uniform
	11	230.00	Uniform
	21	408.00	Uniform
2		(27,835.00)	Employee Meal
	22	27,835.00	Employee Meal
10		(144,684.00)	Oxygen
	39	144,684.00	Oxygen

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Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	81,794	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,472)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(7,387)	21		17
18	Fines and Penalties	(19,155)	32		18
19	Entertainment	(1,194)	20		19
20	Contributions	(3,278)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(21,401)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(128,374)	27		24
25	Fund Raising, Advertising and Promotional	(41,339)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	48	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(461)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,231)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(31,723)	Various	34
35	Other- Attach Schedule See Pg 5A	(161,550)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (193,273)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (335,504)		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

BHF USE ONLY						
48		49		50		51
						52

ALDEN LAKELAND REHAB & HCC

ID# 0017319

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (7,889)	5	1
2	Late fees on telephone	(392)	21	2
3	Gift shop expenses	(39)	41	3
4	Rcls Copier Leases from gl 7053 (interest-other)	2,923	35	4
5	Intercompany interest is not allowed (gl 7031)	(150,345)	32	5
6	Rcls Copier Leases from gl 7053 (interest-other)	(2,923)	32	6
7	Misc Income (record copies)	(57)	10	7
8	Misc Income (jury duty)	(86)	22	8
9	Misc Income (food rebate)	(130)	2	9
10	Misc Income (wage service fee)	(363)	22	10
11	Marketing Manager & Aides	(23,742)	21	11
12	Back out % of Employee Benefits for Mktg Manager	(3,447)	22	12
13	Back out 30.65% of PAC fees from IHCA bills	(3,722)	20	13
14	Vendor Settlements (gl 7143)	6,206	21	14
15	Vendor Settlements: utilities - Commonwealth Edison	(6,206)	5	15
16	Adj Depreciation for capitalized items expensed	(2,029)	30	16
17	Expense Capitalized Items < \$2,500	25,971	6	17
18	Prior year credit for legal fee adjustment	4,720	19	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	(161,550)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(6,334)	0	0	0	0	0	0	0	(6,334)	1
2	Food Purchase	(1,602)	0	0	(76,719)	0	0	0	0	0	0	0	(78,321)	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	(14,095)	0	3,540	0	0	0	0	0	0	0	0	(10,555)	5
6	Maintenance	25,971	0	9,800	0	0	0	(686)	0	0	0	0	35,085	6
7	Other (specify):*	0	0	50,468	4,318	0	0	0	0	0	0	0	54,786	7
8	TOTAL General Services	10,274	0	63,808	(78,735)	0	0	(686)	0	0	0	0	(5,339)	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	(57)	0	0	398	(2,416)	0	0	0	0	0	0	(2,075)	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	44,137	0	0	0	0	0	0	0	0	44,137	15
16	TOTAL Health Care and Programs	(57)	0	44,137	398	(2,416)	0	0	0	0	0	0	42,062	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	(16,681)	11,177	(852,988)	0	0	0	0	0	0	0	0	(858,492)	19
20	Fees, Subscriptions & Promotions	(49,994)	0	2,654	0	0	0	0	0	0	0	0	(47,340)	20
21	Clerical & General Office Expenses	(25,267)	0	39,241	21,691	11,603	0	0	0	0	0	0	47,268	21
22	Employee Benefits & Payroll Taxes	(3,896)	0	0	0	0	0	0	0	0	0	0	(3,896)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,280	0	0	0	0	0	0	0	0	2,280	24
25	Other Admin. Staff Transportation	0	0	12,383	0	0	0	0	0	0	0	0	12,383	25
26	Insurance-Prop.Liab.Malpractice	0	11,138	290	0	0	0	0	0	0	0	0	11,428	26
27	Other (specify):*	(128,374)	0	494,995	28,023	12,610	0	0	0	0	0	0	407,254	27
28	TOTAL General Administration	(224,212)	22,315	(301,145)	49,714	24,213	0	0	0	0	0	0	(429,115)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(213,995)	22,315	(193,200)	(28,623)	21,797	0	(686)	0	0	0	0	(392,392)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06 Ending:

12/31/06

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	79,765	382,367	5,278	0	1,858	0	0	0	0	0	0	469,268	30
31	Amortization of Pre-Op. & Org.	0	1,650	3,406	0	0	0	0	0	0	0	0	5,056	31
32	Interest	(172,435)	716,362	113,999	0	1,557	1,709	0	0	0	0	0	661,192	32
33	Real Estate Taxes	0	231,401	7,878	0	582	0	0	0	0	0	0	239,861	33
34	Rent-Facility & Grounds	0	(1,212,354)	0	0	0	0	0	0	0	0	0	(1,212,354)	34
35	Rent-Equipment & Vehicles	2,923	0	44,555	0	0	0	0	0	0	0	0	47,478	35
36	Other (specify):*	0	58,366	0	0	0	0	0	0	0	0	0	58,366	36
37	TOTAL Ownership	(89,747)	177,792	175,116	0	3,997	1,709	0	0	0	0	0	268,867	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	(129,761)	(41,420)	(40,759)	0	0	0	0	0	(211,940)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(39)	0	0	0	0	0	0	0	0	0	0	(39)	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	(39)	0	0	(129,761)	(41,420)	(40,759)	0	0	0	0	0	(211,979)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(303,781)	200,107	(18,084)	(158,384)	(15,626)	(39,050)	(686)	0	0	0	0	(335,504)	45

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group, Ltd.	100	See Pg 6K		See Pg 6K		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,212,354			\$	\$ (1,212,354)	1
2	V	32 Interest Income Repl Reserve	853				(853)	2
3	V	19 Accounting Fees		Lawrence Avenue Building Limited Partnership		300	300	3
4	V	33 Real Estate Tax Expense		Lawrence Avenue Building Limited Partnership		231,401	231,401	4
5	V	26 Property and Liability Insurance		Lawrence Avenue Building Limited Partnership		11,138	11,138	5
6	V	32 Interest on Mortgage Note		Lawrence Avenue Building Limited Partnership		717,215	717,215	6
7	V	36 Mortgage Insurance Premium		Lawrence Avenue Building Limited Partnership		58,366	58,366	7
8	V	30 Depreciation Expense		Lawrence Avenue Building Limited Partnership		382,367	382,367	8
9	V	31 Amortization Expense		Lawrence Avenue Building Limited Partnership		1,650	1,650	9
10	V	19 Misc Admin Expense		Lawrence Avenue Building Limited Partnership		10,877	10,877	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,213,207			\$ 1,413,314	\$ * 200,107	14

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/06Ending: 12/31/06

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		\$	Alden Management Services, Inc.		\$		15
16	V	19 Professional Fees	883,200			30,212	(852,988)	16
17	V	21 General & Admin				39,241	39,241	17
18	V	5 Utilities				3,540	3,540	18
19	V	6 Repairs & Maintenance				9,800	9,800	19
20	V	24 Travel & Seminar				2,280	2,280	20
21	V	25 Other Admin Travel				12,383	12,383	21
22	V	26 Insurance				290	290	22
23	V	20 Dues & Subscriptions				2,654	2,654	23
24	V	30 Depreciation				5,278	5,278	24
25	V	31 Amortization				3,406	3,406	25
26	V	33 Real Estate Taxes				7,878	7,878	26
27	V	34 Rent						27
28	V	35 Rent-Equipment & Vehicle				44,555	44,555	28
29	V	32 Interest				113,999	113,999	29
30	V	7 General Serv Salary				50,468	50,468	30
31	V	15 Health Care Salary				44,137	44,137	31
32	V	27 G & A Salaries				494,995	494,995	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 883,200			\$ 865,116	\$ * (18,084)	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	\$ 9,600	Prism Health Care Services, Inc.		\$ 3,266	\$ (6,334)
16	V	2 Tube Feeding	143,879			67,160	(76,719)
17	V	10 Equipment Rentals	3,060			3,458	398
18	V	39 Supplies	266,727			82,190	(184,537)
19	V	7 Dietary Salary				4,318	4,318
20	V	39 Vent Rentals				54,776	54,776
21	V	27 G & A Salary				28,023	28,023
22	V	21 G & A				21,691	21,691
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		\$ 423,266			\$ 264,882	\$ * (158,384)

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/06Ending: 12/31/06

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	\$ 167,992	Forum Extended Care Services II, Inc.		\$ 235,870	\$ 67,878	15
16	V	39	I.V.	118,652	Forum Extended Care Services II, Inc.		12,282	(106,370)	16
17	V	39	Wound Care	13,416	Forum Extended Care Services II, Inc.		10,488	(2,928)	17
18	V	10	House Stock	12,297	Forum Extended Care Services II, Inc.		11,085	(1,212)	18
19	V	10	Pharm Consult	10,180	Forum Extended Care Services II, Inc.		8,976	(1,204)	19
20	V	27	Employ Vaccin	1,446	Forum Extended Care Services II, Inc.		1,130	(316)	20
21	V	27	G & A Salary		Forum Extended Care Services II, Inc.		12,926	12,926	21
22	V	21	General & Admin		Forum Extended Care Services II, Inc.		11,603	11,603	22
23	V	32	Interest		Forum Extended Care Services II, Inc.		1,557	1,557	23
24	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		582	582	24
25	V	30	Depreciation		Forum Extended Care Services II, Inc.		1,858	1,858	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		\$ 323,983			\$ 308,357	\$ *	(15,626)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	\$ 665,716	Community Physical Therapy & Associates, Ltd.		\$ 624,957	\$ (40,759)	15
16	V	32	Interest				1,709	1,709	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			\$ 665,716			\$ 626,666	\$ * (39,050)	39

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 44,902	Alden Bennett Construction Company, Inc.		\$ 44,216	\$ (686)	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			\$ 44,902			\$ 44,216	\$ *	(686) 39

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

ALDEN NURSING CENTER - Lakeland

0017319

Report Period Beginning 01/01/06

Ending: 12/31/06

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

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 LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	President	President	Chief Executive	100.00	131,157	2.392	5.98	salary	\$ 8,343	27-7	1
2	Nurse coordinator	Nurse coordinator	nursing admin.	0.00	76,875	2.392	5.98	salary	4,890	15-7	2
3	Maint. Supervisor	Maint. Supervisor	construct/mainten	0.00	49,873	2.392	5.98	salary	3,172	7-7	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of The Alden Group, Limited										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											10
11											11
12											12
13								TOTAL	\$ 16,405		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.

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Cambridge		X	mortgage	\$87,518.00	8/27/02	\$ 11,977,000	\$ 11,640,614	8/26/42	6.1400	\$ 717,215	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Related Party - CPT	X		Working capital							1,709	6								
7	Related Party - AMS	X		Working capital							113,999	7								
8	Related Party - FECII	X		Working capital							1,557	8								
9	TOTAL Facility Related				\$87,518.00		\$ 11,977,000	\$ 11,640,614			\$ 834,480	9								
B. Non-Facility Related*																				
10	Interest Income Replacement Reserve										(853)	10								
11	Interest and Other Investment Income										(12)	11								
12	Therapeutic Systems										306	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(559)	14								
15	TOTALS (line 9+line14)						\$ 11,977,000	\$ 11,640,614			\$ 833,921	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 58,366 Line # 36

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

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning: 01/01/06

Ending: 12/31/06

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (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 2005 report.		\$ 332,400	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.)		\$ 337,321	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 4,921	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 347,400	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.)		\$ (120,920)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 231,401	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	346,350	8
	2002	350,233	9
	2003	315,686	10
	2004	322,699	11
	2005	337,321	12
<u>accrual based on 3% increase over last year.</u>			
FOR BHF USE ONLY			
	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:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 LAKELAND REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0017319

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 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>14-08-419-040-0000</u>	<u>Nursing Home Facility</u>	\$ <u>337,321.23</u>	\$ <u>337,321.23</u>
2. <u>See Attached</u>	<u>Related Party - Alden Management</u>	\$ <u>131,720.00</u>	\$ <u>7,878.00</u>
3. <u>See Attached</u>	<u>Related Party - Forum</u>	\$ <u>14,554.00</u>	\$ <u>582.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>483,595.23</u>	\$ <u>345,781.23</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 LAKELAND REHAB & HCC

0017319 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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>300 bed facility</u>		<u>1995</u>	<u>\$ 1,040,000</u>	1
2					2
3	TOTALS			\$ 1,040,000	3

Facility Name & ID Number **ALDEN LAKELAND REHAB & HCC**

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	related party-forum			1978	\$ 14,839	\$	25	\$	\$	\$ 14,839	4
5	300			1978	8,882,363	222,111	40	222,059	(52)	2,781,993	5
6			1995		577		40	14	14	162	6
7			1995		245		40	6	6	69	7
8				1996	13,250		40			2,953	8
	Improvement Type**										
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

*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 LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	GENERAL REMODELING	1994	\$ 1,640,753	\$ 42,645	15	\$ 109,384	\$ 66,739	\$ 1,317,248	37
38	NEW AIR CONDITIONER	1994	185,718	4,827	15	12,381	7,554	143,045	38
39	OXYGEN AND SUCTION SYSTEM	1994	89,080	2,315	15	5,939	3,624	70,931	39
40	3RD FLOOR NURSES STATION	1994	14,234	370	15	949	579	11,058	40
41	REBUILD SHOWERS AND STALL	1994	47,131	1,225	15	3,142	1,917	37,054	41
42	PATIENT ROOM LIGHTING	1994	34,763	903	15	2,318	1,415	27,008	42
43	CARPETING	1994	20,688		10			17,306	43
44	NEW DOOR LOCK AND HARDWARE	1994	25,312		10			21,382	44
45	VARIOUS OTHER ITEMS	1994	85,896		10			55,265	45
46	DECORATING	1986	5,000		3			5,000	46
47	DECORATING,PUMPS, ROOF REPAIR, COMPRESSOR REPAIR	1987	15,543		3-5			15,543	47
48	ELECTRICAL REPAIRS, CARPENTRY,PUMP REPAIR	1988	15,804		5			15,804	48
49	PUMP REPAIR	1989	2,510		5			2,510	49
50	REPAIR: PUMPS AND COMPRESSOR	1990	32,782		5-10			32,782	50
51	REPAIR: PUMPS, FANS, HEATER,ROOF	1991	16,753		5			16,753	51
52	REPAIR: BOILER,FANS, THERMOSTAT	1992	32,033	59	5-20	58	(1)	32,149	52
53	COLOR RENDERING,REPAIR: COOLING TOWER, ELECT TIMER,	1993	8,916	490	5-15	490		8,215	53
54	DRAPERIES AND CUBICLES; COMPRESSOR REPAIR	1994	45,438	565	5-20	565		43,821	54
55	REPAIR: ELEVATOR, LAUNDRY ROOM, PUMPS,A.C, INSULLATIO	1995	415,705	17,541	5-20	17,541	(0)	279,198	55
56	NEW ELECTRIC GENERATOR, NEW COOLING TOWER	1996	191,725	9,510	5-20	9,510		104,546	56
57	INSTALL NEW CIRCUITS	1997	2,176		5			2,176	57
58	CLEAN FAN COILS	1997	4,622		5			4,622	58
59	REPAIR LIGHTING CIRCUIT & BALLAST	1997	2,327		5			2,327	59
60	REBUILD COMPRESSOR	1997	4,268		5			4,268	60
61	REPAIR CALL LIGHTS	1997	2,350		5			2,350	61
62	ISTALL NEW SMOKE DETECTOR	1997	2,661		5			2,661	62
63	SPRAYED FIREPROOFING	1997	3,965		5			3,965	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,859,427	\$ 302,561		\$ 384,355	\$ 81,794	\$ 5,079,002	70

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,859,427	\$ 302,561		\$ 384,355	\$ 81,794	\$ 5,079,002	1
2	Climate Service, Inc (replace fans)	1998	4,725		5			4,725	2
3	**Wigdahl(replaced outlets)	1998	2,300	230	10	230		2,051	3
4	Wigdahl(replaced outlets)	1998	334	33	10	33		297	4
5	Long Elevator(modify restrictors)	1998	2,200	110	20	110		972	5
6	Incorporation(kickplates & corer guards)	1998	2,309		5			2,309	6
7	Incorporation(kickplates & larone)	1998	4,547		5			4,547	7
8	Shine Rite Maintenance (strip and refinish 30 rooms)	1998	6,480		5			6,480	8
9	Star Contractors (install locks)	1998	5,581	558	10	558		4,930	9
10	Supreme Sheet Metal (Fire dampers)	1998	10,000	667	15	667		5,667	10
11	CSI (replace fan coil units)	1998	6,340	423	15	423		3,523	11
12	Atash Fire & Safety (install annunciator panel)	1998	5,890	393	15	393		3,371	12
13	CSI (rebuild compressor)	1998	7,056	470	15	470		3,919	13
14	Supreme Sheet Metal (install fire dampers)	1998	11,680	1,168	10	1,168		9,636	14
15	Alden Bennett Construction (plan of correction)	1998	2,222	222	10	222		1,814	15
16	Supreme Sheet Metal (install fire dampers)	1998	7,750	775	10	775		6,265	16
17	Supreme Sheet Metal (install fire dampers)								17
18	Patton (repair generator)	1999	1,702	113	15	113		907	18
19	Alden Bennett Construction(general)	1999	11,471	1,147	10	1,147		8,507	19
20	Welding Supply(oxygen piping installed)	1999	13,176	659	20	659		4,777	20
21	ISS/Chicago Sound & Comm.(call system)	1999	28,500	1,900	15	1,900		13,617	21
22	Alden Bennett Construction(general)	1999	23,560	1,571	15	1,571		11,126	22
23	Alden Bennet Construction- oxygen tank	1999	9,475	474	20	474		3,317	23
24	Alden Bennett Construction(oxyg tank)	1999	35,016	1,751	20	1,751		12,327	24
25	Supreme sheet metal-install fire dampers-delete duplicate	2000	(9,475)	(948)	10	(948)		(6,632)	25
26	Climate Service, Inc (repair boiler)	2000	4,892	245	20	245		1,712	26
27	A&B custom cable-install cable tv	2000	13,824	1,382	10	1,382		9,330	27
28	Fox Valley-install new fire safety pump	2000	4,423	221	20	221		1,492	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,075,405	\$ 316,125		\$ 397,919	\$ 81,794	\$ 5,199,988	34

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 12B, Carried Forward		\$ 12,075,405	\$ 316,125		\$ 397,919	\$ 81,794	\$ 5,199,988	1
2	Fox Valley-repair hvac pump	2000	1,969	98	20	98		664	2
3	System electric-circuit for sump pump	2000	2,361	118	20	118		787	3
4	System electric-emergency lighting	2000	5,190	346	15	346		2,278	4
5	System Electric-install circuits	2000	1,570	78	20	78		509	5
6	Fox Valley-install tank system	2000	1,755	70	25	70		456	6
7	GT Mechanical-repair boiler	2000	2,698	135	20	135		877	7
8	ABC-fireproofing	2000	2,503	125	20	125		792	8
9	ABC-seal & stripe parking lot	2000	977	98	10	98		603	9
10	Richard G. Radke-color rendering	1993	6,620		5			6,620	10
11	Remodeling-Lawrence Ave Partnership (building)	1994	140,050	3,501	40	3,501		42,015	11
12	ABC-oxygen tank wiring	2000	26,715		3			26,715	12
13	ABC-wallpapering	2000	3,543		3			3,543	13
14	EWS - Oxygen tank repairs	2001	2,157	270	8	270		1,529	14
15	Simplex Time Recorder (fire alarm repairs)	2001	1,810	121	15	121		674	15
16	Simplex Time Recorder (fire alarm repairs)	2001	1,529	102	15	102		569	16
17	GT Mechanical-replace trane rooftop unit	2001	17,800	1,187	15	1,187		6,527	17
18	Long Elevator-repair elevator	2001	757	76	10	76		411	18
19	Long Elevator-replace boards	2001	4,659	466	10	466		2,524	19
20	Alden Bennett - various	2001	1,720	172	10	172		960	20
21	Alden Bennett - various	2001	8,688	579	15	579		3,137	21
22	Alden Bennett - various	2001	11,481	765	15	765		4,018	22
23	Medline Industries	2002	1,205	120	10	120		511	23
24	GT Mechanical-replace relay board/compressor	2002	1,696	113	15	113		509	24
25	CSI Coker- booster heater	2002	5,238	349	15	349		1,716	25
26	Alden Bennett -building improvement	2002	3,358	224	15	224		1,064	26
27	Alden Bennett -building improvement	2002	2,478	248	10	248		1,012	27
28	Alden Bennett -building improvement	2002	3,161	316	10	316		1,343	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,339,092	\$ 325,802		\$ 407,596	\$ 81,794	\$ 5,312,350	34

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 12,339,092	\$ 325,802		\$ 407,596	\$ 81,794	\$ 5,312,350	1
2	GT Mechanical-rebuild compressor	2003	6,500	433	15	433	0	1,698	2
3	Simplex Grinnell -replace smoke detectors	2003	4,225	423	10	423	(0)	1,655	3
4	Simplex Grinnell-repair fire pump	2003	2,094	209	10	209	0	768	4
5	Simplex Grinnell fire system connection	2003	1,710	171	10	171		627	5
6	CSI Coker-Hobart dishwasher	2003	1,522	304	5	304		1,040	6
7	Simplex Grinnell-2 duct smoke detectors	2003	1,620	162	10	162	0	540	7
8	Simplex Grinnell-2 duct smoke detectors & electric	2003	1,961	196	10	196	(0)	637	8
9	GT Mechanical-repair boiler	2003	1,340	268	5	268	0	849	9
10	GT Mechanical-replace boiler relief valve	2003	931	186	5	186	0	589	10
11	Alden Bennett Cons.-roof repair & rails installed	2003	7,517	752	10	752	(0)	2,443	11
12	GT Mchanical-back up pump bearing	2004	1,713	171	10	171		485	12
13	GT Mchanical-main house pump	2004	1,555	156	10	156		416	13
14	GT Mechanical-cooling towwe repairs	2004	1,259	125	10	125		1,094	14
15	CAPPS Plumbing-replaced kitchen faucets, drains	2004							15
16	ABC-repair kitchen, freezer doors and misc repairs	2004	8,038	804	10	804		2,144	16
17	Oak First Signal Circuit-elevator repair	2004	2,075	208	10	208		520	17
18	ABC misc repairs	2004	6,005	600	10	600		1,550	18
19	GT Mechanical-laundry motor replacement	2004	2,966	297	10	297		742	19
20	GT Mechanical-cooling gtower fan motor	2004	4,181	418	10	418		1,045	20
21	ISS/chicao Sound/ repair address sound	2004	2,092	209	10	209		505	21
22	ABC misc repairs	2004	5,832	583	10	583		1,409	22
23	GT Mechanical-A/C for East side of bldg	2004	1,007	101	10	101		244	23
24	System Electric-walk in cooler lights	2004	904	60	15	60		140	24
25	Oak First-installation of smoke dectors in front of elevators	2004	6,500	650	10	650		1,463	25
26	Top Notch-repaired faucet/drains	2004	1,627	163	10	163		340	26
27	ABC-Medical Gas Revisions	2004	27,009	2,700	10	2,700		7,426	27
28	CAPPS Plumbing-replaced kitchen faucets, drains	2005	1,320	66	20	66		198	28
29	Cybor Fire Protection Fire Sprinkler	2005	3,195	456	7	456		646	29
30	ABC New water cooling system	2005	153,553	7,678	20	7,678		12,157	30
31	ABC New water cooling system	2005	12,097	605	20	605		857	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,611,440	\$ 344,957		\$ 426,751	\$ 81,794	\$ 5,356,578	34

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

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 12D, Carried Forward		\$ 12,611,440	\$ 344,957		\$ 426,751	\$ 81,794	\$ 5,356,578	1
2	OakFire - install smoke detectors in elevator shaft	2006	8,528	284	10	284		284	2
3	ABC - install new sheet flooring in resident/ laundry room	2006	4,368	328	10	328		328	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,624,336	\$ 345,569		\$ 427,363	\$ 81,794	\$ 5,357,190	34

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 12E, Carried Forward		\$ 12,624,336	\$ 345,569		\$ 427,363	\$ 81,794	\$ 5,357,190	1
2	Leasehold Improvement-Remodeling	1980	11,260		15			11,260	2
3	Leasehold Improvement-Remodeling	1980	17,639		20			17,639	3
4	Leasehold Improvement-Tenant Improvement	1987	912		13			912	4
5	Leasehold Improvement-AMS Remodel	1988	14,634		10			14,634	5
6	Leasehold Improvement-Roof	1994	3,269	204	16	204		2,453	6
7	Leasehold Improvement-Build.Improv.	1996	1,153	72	16	72		789	7
8	Leasehold Improvement-Asphalting	2000	89		3			89	8
9	Leasehold Improvement-DAI	2001	157	16	10	16		81	9
10	Leasehold Improvement-Bathrooms	2002	681	77	7	77		324	10
11	Leasehold Improvement-Suite Renovation	2003	1,672	167	10	167		669	11
12	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	2,071	360	7	360		835	12
13	Leasehold Improvement-Add-on Improvement, fixture base	1980	73		23			73	13
14	Leasehold Improvement-Add-on Improvement, lighting base	2001	126	6	5	6		126	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Related Party-AMS:								24
25	Leasehold Improvement-Remodeling	1993	6,060		7			6,060	25
26	Leasehold Improvement-Remodeling	2002	4,961	709	7	709		2,746	26
27	Leasehold Improvement-Remodeling	2003	5,189	741	7	741		2,856	27
28									28
29									29
30									30
31	Forum Extended Care, LLC-building/building improv	1999	12,434	293	30	293		2,350	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,706,716	\$ 348,214		\$ 430,008	\$ 81,794	\$ 5,421,086	34

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

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 1,832,398	\$ 137,208	\$ 137,208	\$	Various	\$ 1,424,575	71
72	Current Year Purchases	27,634	916	916		Various	916	72
73	Fully Depreciated Assets	332,125	3,121	3,121		Various	332,125	73
74								74
75	TOTALS	\$ 2,192,157	\$ 141,245	\$ 141,245	\$		\$ 1,757,616	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	Related Party - AMS	Chev/Lumina /'00/Various	98-'04	\$ 4,817	\$ 113	\$ 113	\$	3	\$ 4,787	76
77										77
78										78
79										79
80	TOTALS			\$ 4,817	\$ 113	\$ 113	\$		\$ 4,787	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)	\$ 15,943,690	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 489,572	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 571,366	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 81,794	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,183,489	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 Rent is eliminated

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 3/31/04

Ending 3/31/14

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

Fiscal Year Ending Annual Rent

12.	<u>/2007</u>	\$ <u>Varies</u>
13.	<u>/2008</u>	\$ <u>Varies</u>
14.	<u>/2009</u>	\$ <u>Varies</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,250 Description: Copy machine rental

(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>44,555</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>44,555</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.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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	39-3	hrs	\$		\$ 201,048	\$		\$ 201,048	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			49,657			49,657	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			207,168			207,168	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				235,870		235,870	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program			835,350			114,820		950,170	12
13	Other (specify):	See Pg 16A				(40,760)	530,262		489,502	13
14	TOTAL			\$ 835,350		\$ 417,113	\$ 880,952		\$ 2,133,415	14

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

XIV. Special Services (Direct Cost)

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

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	\$201,047.92
2. ST	39-3	To Col 5	49,656.83
3.			
4. PT	39-3	To Col 5	207,168.39
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			167,992.02
Manual Input from Related Party- Forum Drugs			67,878.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	<u>235,870.02</u>
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	835,349.54
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	114,820.24
Total Exceptional Care (Line 12, Col 8)			<u>950,169.78</u>
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	(40,760.00)
Other			624,636.26
Manual Input: Related Party - Prism			(129,761.00)
Manual Input: Related Party FECII - I.V.			(106,369.00)
Manual Input: Related Party FECII - Wound Care			(2,928.00)
Oxygen, from reclass worksheet			144,684.00
13. Col 6: Supplies Total		To Col 6	<u>530,262.26</u>
13. Total Line 13, Column 8			<u>489,502.26</u>
14. Total			<u><u>2,133,415.20</u></u>

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$	\$ 358	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>74,830</u>)	3,134,587	3,134,587	3
4	Supply Inventory (priced at)	264	264	4
5	Short-Term Investments			5
6	Prepaid Insurance		12,527	6
7	Other Prepaid Expenses		46,367	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	128,546	128,546	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,263,397	\$ 3,322,649	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,040,001	13
14	Buildings, at Historical Cost		11,253,031	14
15	Leasehold Improvements, at Historical Cost	1,568,310	1,738,475	15
16	Equipment, at Historical Cost	714,872	2,136,233	16
17	Accumulated Depreciation (book methods)	(1,589,194)	(6,264,042)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		65,981	19
	Accumulated Amortization - Organization & Pre-Operating Costs		(7,148)	20
21	Restricted Funds		361,828	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 693,988	\$ 10,324,359	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,957,385	\$ 13,647,008	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,013,195	\$ 1,014,455	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	114,165	114,165	28
29	Short-Term Notes Payable		92,707	29
30	Accrued Salaries Payable	529,639	529,639	30
	Accrued Taxes Payable (excluding real estate taxes)	34,294	34,294	31
32	Accrued Real Estate Taxes(Sch.IX-B)		347,400	32
33	Accrued Interest Payable		59,561	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>accr ins, exps, idpa, sales tax</u>	248,652	262,348	36
37	<u>Due to related parties</u>	1,313,055		37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,253,000	\$ 2,454,569	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,547,907	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to affiliates</u>	15,154,251	15,154,251	43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 15,154,251	\$ 26,702,158	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 18,407,251	\$ 29,156,727	46
47	TOTAL EQUITY (page 18, line 24)	\$ (14,449,866)	\$ (15,509,719)	47
	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,957,385	\$ 13,647,008	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (12,667,598)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (12,667,598)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,782,268)	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)	\$ (1,782,268)	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)	\$ (14,449,866)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 9,891,032	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,891,032	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	39,172	6
7	Oxygen	286,194	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 325,366	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	45	15
16	Rental of Facility Space		16
17	Sale of Drugs	769	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	209	19
20	Radiology and X-Ray		20
21	Other Medical Services	110,876	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 111,899	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG 19A	8,926	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,926	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,337,235	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,786,244	31
32	Health Care	3,795,129	32
33	General Administration	2,677,739	33
B. Capital Expense			
34	Ownership	1,495,431	34
C. Ancillary Expense			
35	Special Cost Centers	2,200,710	35
36	Provider Participation Fee	164,250	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,119,503	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,782,268)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,782,268)	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.

Misc Income (Payroll Income)	449.00
Misc Income (Food Credits)	186.82
Adjustment to prior year expense	8,290.05

0.00 8,925.87
=====

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

0017319

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,589	2,068	\$ 80,920	\$ 39.13	1
2	Assistant Director of Nursing	40	40	2,176	54.40	2
3	Registered Nurses	44,097	46,366	1,560,068	33.65	3
4	Licensed Practical Nurses	32,853	34,291	932,112	27.18	4
5	CNAs & Orderlies	102,231	108,132	1,168,485	10.81	5
6	CNA Trainees					6
7	Licensed Therapist	5,974	6,062	167,176	27.58	7
8	Rehab/Therapy Aides	2,171	2,406	32,840	13.65	8
9	Activity Director	1,976	2,086	29,028	13.92	9
10	Activity Assistants	5,217	5,690	50,818	8.93	10
11	Social Service Workers	2,248	2,425	42,092	17.36	11
12	Dietician					12
13	Food Service Supervisor	1,937	2,081	35,579	17.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,250	24,208	242,048	10.00	15
16	Dishwashers					16
17	Maintenance Workers	2,064	2,200	46,049	20.93	17
18	Housekeepers	23,441	25,479	255,023	10.01	18
19	Laundry	7,007	7,620	89,035	11.68	19
20	Administrator	2,080	2,440	116,255	47.65	20
21	Assistant Administrator	1,920	2,080	57,656	27.72	21
22	Other Administrative	4,448	4,736	129,252	27.29	22
23	Office Manager	1,960	2,160	32,713	15.14	23
24	Clerical	2,467	2,509	23,625	9.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,928	2,080	60,165	28.93	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Behavioral Counselor	3,409	3,482	63,884	18.35	32
33	Other(specify) Security	4,661	4,750	43,672	9.19	33
34	TOTAL (lines 1 - 33)	277,968	295,391	\$ 5,260,671 *	\$ 17.81	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	800/Monthly	\$ 9,600	1-3	35
36	Medical Director	4332/Monthly	51,987	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	600/Monthly	7,200	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	13	976	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	13	\$ 69,763		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

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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	hvac/pipes/pumps/repairs	1/88	\$ 3,500	5	\$	\$	\$	\$	\$	\$	\$	\$	\$
2	hvac/pipes/pumps/repairs	2/88	2,444	5									
3	hvac/pipes/pumps/repairs	3/88	2,385	5									
4	hvac/pipes/pumps/repairs	7/88	1,766	5									
5	hvac/pipes/pumps/repairs	10/88	3,200	5									
6	hvac/pipes/pumps/repairs	12/88	2,510	5									
7	boiler/hvac repair	6/89	5,114	5									
8	fan/pump/boiler repairs	10/90	4,240	5									
9	fan/pump/boiler repairs	11/90	3,482	5									
10	fan/pump/boiler repairs	12/90	2,233	5									
11	see page 22a	1991-1995	220,093	5-20	1,540	1,540	1,540	1,540	1,540	1,540	1,540	1,540	797
12	see page 22b	1996	41,372	3-20	696	696	696	696	696	696	505	505	505
13	see page 22c	1997	16,366	3									
14	see page 22c	1998	103,843	3									
15	see page 22d	1999	18,157	3	0								
16	painting>\$1,500 ytd 1999	7/99	12,619	3	0								
17	see page 22d	2000	15,388	3	2,964	133	0						
18													
19													
20	TOTALS		\$ 458,712		\$ 5,200	\$ 2,369	\$ 2,236	\$ 2,236	\$ 2,236	\$ 2,236	\$ 2,045	\$ 2,045	\$ 1,302

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Il. Health Care Assn. \$12,144
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,220 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. \$ 164,250
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. \$ 27,835 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? No If no, please explain. 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.