

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709 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	96	Skilled (SNF)	96	35,040	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	96	TOTALS	96	35,040	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	4,800	1,167	4,740	10,707	8
9	SNF/PED					9
10	ICF	12,075	3,547		15,622	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,875	4,714	4,740	26,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.14%

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 03/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/95 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 33 and days of care provided 4,196

Medicare Intermediary AdminaStar Federal

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 Lincoln Rehab & H C Ctr # 0040709 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
	A. General Services										
1	Dietary	202,267	13,429	9,600	225,296	686	225,982	(6,334)	219,648		1
2	Food Purchase		158,380		158,380	(18,198)	140,182	(18,657)	121,525		2
3	Housekeeping	75,616	22,469		98,085	216	98,301		98,301		3
4	Laundry	60,789	5,708		66,497	261	66,758		66,758		4
5	Heat and Other Utilities			106,928	106,928		106,928	(785)	106,143		5
6	Maintenance	52,415		70,880	123,295	91	123,386	13,342	136,728		6
7	Other (specify):* Related Party Salary							24,183	24,183		7
8	TOTAL General Services	391,087	199,986	187,408	778,481	(16,944)	761,537	11,749	773,286		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,329,631	87,664	10,196	1,427,491	(22,925)	1,404,566	(693)	1,403,873		10
10a	Therapy										10a
11	Activities	40,885	1,661	1,870	44,416	58	44,474		44,474		11
12	Social Services	39,196			39,196		39,196		39,196		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Salary							17,373	17,373		15
16	TOTAL Health Care and Programs	1,409,712	89,325	21,666	1,520,703	(22,867)	1,497,836	16,680	1,514,516		16
	C. General Administration										
17	Administrative	78,888			78,888		78,888		78,888		17
18	Directors Fees										18
19	Professional Services			347,630	347,630		347,630	(300,424)	47,206		19
20	Dues, Fees, Subscriptions & Promotions			41,210	41,210		41,210	(31,492)	9,718		20
21	Clerical & General Office Expenses	70,041	9,166	31,923	111,130	207	111,337	11,683	123,020		21
22	Employee Benefits & Payroll Taxes			289,453	289,453	14,403	303,856		303,856		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,162	2,162		2,162	898	3,060		24
25	Other Admin. Staff Transportation							4,874	4,874		25
26	Insurance-Prop.Liab.Malpractice			104,793	104,793		104,793	114	104,907		26
27	Other (specify):* Bad debt, Related Party Salary			84,837	84,837		84,837	124,607	209,444		27
28	TOTAL General Administration	148,929	9,166	902,008	1,060,103	14,610	1,074,713	(189,740)	884,973		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,949,728	298,477	1,111,082	3,359,287	(25,201)	3,334,086	(161,311)	3,172,775		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 Lincoln Rehab & H C Ctr

#0040709

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	
	D. Ownership											
30	Depreciation			33,567	33,567		33,567	7,739	41,306			30
31	Amortization of Pre-Op. & Org.							1,341	1,341			31
32	Interest			41,892	41,892		41,892	3,889	45,781			32
33	Real Estate Taxes			120,417	120,417		120,417	3,415	123,832			33
34	Rent-Facility & Grounds			664,721	664,721		664,721		664,721			34
35	Rent-Equipment & Vehicles			7,101	7,101		7,101	17,537	24,638			35
36	Other (specify):* MIP & Amortiz.											36
37	TOTAL Ownership			867,698	867,698		867,698	33,921	901,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		239,792	317,315	557,107	25,201	582,308	(22,713)	559,595			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		239,792	369,875	609,667	25,201	634,868	(22,713)	612,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,949,728	538,269	2,348,655	4,836,652		4,836,652	(150,103)	4,686,549			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 - Lincoln Park
Reporting Period Beginning
Reporting Period Ending

004-0709
01/01/06
12/31/06

PG4A

Reclassifications: PGs 3 & 4

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
22		(3,795.00)	Uniform
	1	686.00	Uniform
	3	216.00	Uniform
	4	261.00	Uniform
	6	91.00	Uniform
	10	2,276.00	Uniform
	11	58.00	Uniform
	21	207.00	Uniform
	22	18,198.00	Employee Meal
2		(18,198.00)	Employee Meal
10		(25,201.00)	Oxygen
	39	25,201.00	Oxygen
Total		<u><u>-</u></u>	

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	(153)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(877)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(480)	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	(5,809)	21		17
18	Fines and Penalties	(2,042)	32		18
19	Entertainment	(431)	20		19
20	Contributions	(2,492)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,043)	21		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,837)	27		24
25	Fund Raising, Advertising and Promotional	(27,775)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,939)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	24,685	Various	34
35	Other- Attach Schedule See Pg 5A	(39,849)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,164)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (150,103)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Alden Lincoln Rehab & H C Ctr

ID# 0040709

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees on Utilities	\$ (2,179)	5	1
2	Late Fees on Telephone	(33)	21	2
3	Intercompany interest	(39,569)	32	3
4	Interest - AFCO	(131)	32	4
5	Misc Income (medical records)	(105)	10	5
6	Misc Income (food rebate)	(420)	2	6
7	Misc Income (polling rental)	(200)	6	7
8	Misc Income (misc payroll diff. refund)	(68)	21	8
9	Vendor Settlement (Marsh USA)	(58)	21	9
10	Vendor Settlement (Marsh USA)	58	6	10
11	Major Repairs less than \$2,500 FY 2006	2,380	6	11
12	Furn & Fixtures less than \$2,500 FY 2006	2,712	6	12
13	Equipment less than \$2,500 FY 2006	4,873	6	13
14	Major Repairs less than \$2,500 - depreciation FY 2006	(32)	30	14
15	Furn & Fixtures less than \$2,500 - depreciation FY 2006	(237)	30	15
16	Equipment less than \$2,500 - depreciation FY 2006	(187)	30	16
17	Eliminate 30.65% of IHCA Pac Fees	(1,839)	20	17
18	Adjust depreciation to P13's	1,058	30	18
19	Adj Deferr. Maint. to match detail	(118)	6	19
20	Back out other users share in Adminastar bill	(5,754)	19	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	(39,849)		49

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	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	\$ 306,562	Alden Management Services, Inc.		\$ 11,892	\$ (294,670)
16	V	21 General & Administrative		Alden Management Services, Inc.		15,446	15,446
17	V	5 Utilities		Alden Management Services, Inc.		1,394	1,394
18	V	6 Repairs and Maintenance		Alden Management Services, Inc.		3,857	3,857
19	V	24 Travel & Seminar		Alden Management Services, Inc.		898	898
20	V	25 Other Administrative Travel		Alden Management Services, Inc.		4,874	4,874
21	V	26 Insurance		Alden Management Services, Inc.		114	114
22	V	20 Sues & Subscription		Alden Management Services, Inc.		1,045	1,045
23	V	30 Depreciation		Alden Management Services, Inc.		5,278	5,278
24	V	31 Amortization		Alden Management Services, Inc.		1,341	1,341
25	V	33 Real Estate Taxes		Alden Management Services, Inc.		3,101	3,101
26	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		17,537	17,537
27	V	32 Interest		Alden Management Services, Inc.		44,871	44,871
28	V	7 General Service Salary		Alden Management Services, Inc.		19,865	19,865
29	V	15 Health Care Salary		Alden Management Services, Inc.		17,373	17,373
30	V	27 G & A Salary		Alden Management Services, Inc.		194,835	194,835
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 306,562			\$ 343,721	\$ * 37,159

* 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	7 Dietary Salary		Prism Health Care Services, Inc.		4,318	4,318
17	V	2 Tube Feeding	30,065	Prism Health Care Services, Inc.		12,461	(17,604)
18	V	10 Equipment Rental	3,060	Prism Health Care Services, Inc.		3,458	398
19	V	39 Supplies	73,899	Prism Health Care Services, Inc.		16,615	(57,284)
20	V	27 G & A Salary		Prism Health Care Services, Inc.		7,721	7,721
21	V	21 G & A Expenses		Prism Health Care Services, Inc.		5,977	5,977
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		\$ 116,624			\$ 53,816	\$ * (62,808)

* 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	\$ 87,850	Forum Extended Care Services II, Inc.		\$ 123,346	\$ 35,496	15
16	V	39 I.V.	73,161	Forum Extended Care Services II, Inc.		7,573	(65,588)	16
17	V	39 Wound Care	4,829	Forum Extended Care Services II, Inc.		3,775	(1,054)	17
18	V	10 House Stock	2,863	Forum Extended Care Services II, Inc.		2,581	(282)	18
19	V	10 Pharmacy Consultant	5,954	Forum Extended Care Services II, Inc.		5,250	(704)	19
20	V	27 Employee Vaccination	447	Forum Extended Care Services II, Inc.		349	(98)	20
21	V	27 G & A Salary		Forum Extended Care Services II, Inc.		6,986	6,986	21
22	V	21 General & Administrative		Forum Extended Care Services II, Inc.		6,271	6,271	22
23	V	32 Interest		Forum Extended Care Services II, Inc.		842	842	23
24	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		314	314	24
25	V	30 Depreciation		Forum Extended Care Services II, Inc.		1,859	1,859	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		\$ 175,104			\$ 159,146	\$ * (15,958)	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	\$ 309,755	Community Physical Therapy & Associates, Ltd.		\$ 375,472	\$ 65,717	15	
16	V	32 Interest		Community Physical Therapy & Associates, Ltd.		795	795	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		\$ 309,755			\$ 376,267	\$ *	66,512	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 and Maintenance	\$ 14,385	Alden Bennett Construction Company, Inc.		\$ 14,165	\$ (220)
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		\$ 14,385			\$ 14,165	\$ * (220)

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

Facility Name & ID Number ALDEN NURSING CENTER - LINCOLN PARK

004-0709

Report Period Beginning 01/01/06

Ending: 12/31/06

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Waterford	Aurora
ANC Northmoor	Chicago
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 Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingtondale
Alden of Old Town West	Bloomingtondale
Alden Trails	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Garden Courts of Des Plaines	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
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 Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 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 A. Schlossberg	President	CEO	100.00	136,216	0.94	2.35	salary	\$ 3,284	27-7	1
2	Lauren Magnussen	Clinical Coordinator	Nursing		79,840	0.94	2.35	salary	1,925	15-7	2
3	Terry Magnussen	Maintenance Supr	Maint.		51,796	0.94	2.35	salary	1,249	7-7	3
4											4
5											5
6											6
7	a. President and sole stockholder of Alden Management Services, Inc.										7
8	b. Daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	\$ 6,458		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 Lincoln Rehab & H C Ctr

0040709 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	See Page 8A (also on Page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Alden Lincoln Rehab & H C Ctr

0040709

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					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	Therapeutic Systems (7059)		X	Working Capital			\$	\$			\$	150						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Related Party - CPT	X		Working Capital								795						
7	Related Party - AMS (6A)	X		Working Capital								44,871						
8	Related Party - FECII	X		Working Capital								842						
9	TOTAL Facility Related						\$	\$			\$	46,658						
B. Non-Facility Related*																		
10	Interest Income - Corp (4946/4975)											(877)						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	(877)						
15	TOTALS (line 9+line14)						\$	\$			\$	45,781						

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

* 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.		\$	121,600	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.)		\$	119,217	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,383)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	122,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	120,417	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	149,072	8
	2002	150,743	9
	2003	115,451	10
	2004	118,016	11
	2005	119,217	12

accrual based on 3% increase over prior year bill.

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 Lincoln Rehab & H C Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040709

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>14-28-108-023-0000</u>	<u>Nursing Home Facility</u>	\$ <u>119,217.00</u>	\$ <u>119,217.00</u>
2. <u>See Attached</u>	<u>Related Party - AMS</u>	\$ <u>131,720.00</u>	\$ <u>3,101.00</u>
3. <u>See Attached</u>	<u>Related Party - Forum</u>	\$ <u>14,554.00</u>	\$ <u>314.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>265,491.00</u>	\$ <u>122,632.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Lincoln Rehab & H C Ctr

0040709

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 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).

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler heads			1995	1,832	73	25	73		824	9
10	Roof repairs			1995	2,000		10			2,000	10
11	Installed Electric AMPS			1996	1,870		5			1,870	11
12	Signs			1996	1,800	105	10	105		1,800	12
13	Water Heater			1997	6,180		5			6,180	13
14	Replace Pipes			1997	5,949		5			5,949	14
15	Exhaust Fans			1997	8,403		5			8,403	15
16	Washing machine motor			1998	1,576	33	8	33		1,576	16
17	ABC (General construction) Major repairs/improvement			1999	5,713	571	10	571		4,284	17
18	ABC (General construction) Major repairs/improvement			1999	2,326	233	10	233		1,726	18
19	ABC (General construction) Major repairs/improvement			1999	2,092	209	10	209		1,551	19
20	ABC (General construction) Major repairs/improvement			1999	1,870	187	10	187		1,340	20
21	ABC (General construction) Major repairs/improvement			1999	12,658	1,266	10	1,266		9,072	21
22	ABC (General construction) Major repairs/improvement			1999	2,250	225	10	225		1,594	22
23	ABC (General construction) Major repairs/improvement			1999	10,225	1,022	10	1,022		7,242	23
24	Climate Services (exhaust fan)			1999	2,280		5			2,280	24
25	Oxygen exhaust system			2000	8,555	1,069	8	1,069		7,396	25
26	Elevator door repair			2000	1,518		5			1,518	26
27	Lawn Sprinkler			2000	15,500	620	25	620		3,927	27
28	ABC (General construction) Major repairs/improvement			2000	6,937		5			6,937	28
29	ABC (General construction) New hot water system			2000	49,596	2,480	20	2,480		16,946	29
30	ABC (General construction) Replace showers			2000	23,903	2,390	10	2,390		15,138	30
31	Replace Fire Pump			2001	3,230	162	20	162		970	31
32	14 Kilowatt water heater booster			2001	2,783	278	10	278		1,484	32
33	ABC (General construction) Major repairs/improvement			2001	3,402	341	5	341		3,402	33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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	Capps Plumbing (pipe & wall repair)	2002	\$ 1,985	\$ 397	5	\$ 397	\$	\$ 1,687	37
38	ABC (misc construction work)	2002	3,442	688	5	688		2,982	38
39	ABC (repair ejector pump)	2002	7,893	1,579	5	1,579		6,710	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		724	40
41	TNS (DSL Cable)	2004	1,358	271	5	271		791	41
42	ABC (1st Floors Stairs)	2004	1,699	170	10	170		354	42
43	Oak Fire security System, new base dual zone card	2005	1,350	270	5	270		293	43
44	Washtown (repair Washer motor)	2005	1,563	313	5	313		443	44
45	ABC (repair Mop basin)	2005	1,613	323	5	323		457	45
46									46
47	ABC - seal holes and replace fill materials 3rd floor	2006	5,793	434	10	434		434	47
48	TopNotch - booster heater	2006	3,217	80	10	80		80	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 232,475	\$ 15,954		\$ 15,954	\$	\$ 145,204	70

**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 12C, Carried Forward		\$ 232,475	\$ 15,954		\$ 15,954	\$	\$ 145,204	1
2									2
3	Related Party-Forum Prof Center Building:								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	Related Party-AMS:								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	Forum Extended Care, LLC-building/building improv	1999	12,434	293	30	293		2,350	33
34	TOTAL (lines 1 thru 33)		\$ 314,854	\$ 18,599		\$ 18,599	\$	\$ 209,100	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	\$ 193,922	\$ 20,780	\$ 20,780	\$	Various	\$ 110,356	71
72	Current Year Purchases	12,934	754	754		Various	754	72
73	Fully Depreciated Assets	110,057	1,060	1,060		Various	110,057	73
74								74
75	TOTALS	\$ 316,913	\$ 22,594	\$ 22,594	\$		\$ 221,167	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	AMS - Bus/Travel Van	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)	\$ 636,584	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,306	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,306	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 435,054	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: TL Enterprises

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:		<u>96</u>		\$ <u>648,240</u>	<u>16</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>96</u>		\$ <u>648,240</u>			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: Purchase Option deposit *

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: \$ 7,101 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 (6A)</u>	<u>various</u>	\$ <u>#####</u>	\$ <u>17,537</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>17,537</u>	21

10. Effective dates of current rental agreement:

Beginning 03/01/1995

Ending 03/01/2010

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

Fiscal Year Ending Annual Rent

12. 12/31/07 \$ 728,248

13. 12/31/08 \$ 728,248

14. 12/31/09 \$ 728,248

* 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

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	\$		\$ 174,070	\$		\$ 174,070	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,823			8,823	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			126,862			126,862	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				123,346		123,346	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program						53		53	12
13	Other (specify):	See Pg 16A				65,717	60,724		126,441	13
14	TOTAL			\$		\$ 375,472	\$ 184,123		\$ 559,595	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	\$174,069.97
2. ST	39-3	To Col 5	8,823.14
3.			
4. PT	39-3	To Col 5	126,862.07
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			87,850.19
Manual Input from Related Party- Forum Drugs			35,496.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	123,346.19
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	53.53
Total Exceptional Care (Line 12, Col 8)			53.53
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	65,717.00
Other			159,449.02
Manual Input: Related Party - Pyramic			(57,284.00)
Manual Input: Related Party FECII - I.V			(65,588.00)
Manual Input: Related Party FECII - Wound Care			(1,054.00)
Oxygen, from reclass worksheet			25,201.00
13. Col 6: Supplies Total		To Col 6	60,724.02
13. Total Line 13, Column 8			126,441.02
14. Total			559,595.92

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>78,000</u>)	834,819		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,052		6
7	Other Prepaid Expenses	11,521		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd Parties</u>	28,547		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 879,939	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	306,720		15
16	Equipment, at Historical Cost	231,972		16
17	Accumulated Depreciation (book methods)	(350,388)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	142,330		21
22	Other Long-Term Assets (specify: <u>Purchase Options</u>)	288,000		22
23	Other(specify): <u>Due from Affiliates</u>	1,670,044		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,288,678	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,168,617	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 332,934	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	213,636		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	211,478		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,577		31
32	Accrued Real Estate Taxes(Sch.IX-B)	122,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued & Deferred Rent</u>	566,736		36
37	<u>Due from IDPA for Audit, accr ins, sales t</u>	71,709		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,529,870	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Affiliates</u>	915,728		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 915,728	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,445,598	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 723,019	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,168,617	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,360,264	1
2	Restatements (describe):		2
3	external audit adj made after 2005 cost report was submitted	(189,432)	3
4	submitted. These have no effect on prior year's report.		4
5	Bad debt, Medicare revenues (non-allowables)		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,170,832	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(447,813)	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)	\$ (447,813)	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)	\$ 723,019	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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,262,518	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,262,518	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,447	6
7	Oxygen	15,689	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 90,136	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	392	13
14	Non-Patient Meals	153	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,333	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	808	19
20	Radiology and X-Ray		20
21	Other Medical Services	28,829	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,515	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	877	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 877	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	793	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 793	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,388,839	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	778,481	31
32	Health Care	1,520,703	32
33	General Administration	1,060,103	33
	B. Capital Expense		
34	Ownership	867,698	34
	C. Ancillary Expense		
35	Special Cost Centers	557,107	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,836,652	40
41	Income before Income Taxes (line 30 minus line 40)**	(447,813)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (447,813)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

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

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

Facility Name & ID Number

Alden Nursing Center - Lincoln Park

004-0709

Report Period Beginning:

01/01/06

Ending:

12/31/2006

Detail of Other Income

Recovery of bad debts

Miscellaneous Income:

Misc payroll diff, refund, polling rentals, othe	68
Food credit	620
Medical records	105

Total to page 19, Line 28

793

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709

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	1,271	1,391	\$ 43,710	\$ 31.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,773	19,731	594,108	30.11	3
4	Licensed Practical Nurses	5,991	6,412	142,061	22.16	4
5	CNAs & Orderlies	40,836	44,695	477,992	10.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	688	949	15,349	16.17	9
10	Activity Assistants	2,816	3,000	25,536	8.51	10
11	Social Service Workers	1,832	1,994	39,196	19.66	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,080	41,213	19.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,538	14,899	161,054	10.81	15
16	Dishwashers					16
17	Maintenance Workers	1,928	2,080	52,415	25.20	17
18	Housekeepers	6,961	7,612	75,615	9.93	18
19	Laundry	6,446	6,934	60,789	8.77	19
20	Administrator	1,920	2,124	78,888	37.14	20
21	Assistant Administrator					21
22	Other Administrative	1,808	2,080	46,037	22.13	22
23	Office Manager					23
24	Clerical	2,820	2,914	24,004	8.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,640	1,748	30,468	17.43	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Alzheimer Supervi</u>	2,606	2,734	41,293	15.10	33
34	TOTAL (lines 1 - 33)	113,794	123,377	\$ 1,949,728 *	\$ 15.80	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly \$ 9,600	1-3	35
36	Medical Director	monthly 9,600	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	43 2,304	10-3	39
40	Physical Therapy Consultant	0	11-3	40
41	Occupational Therapy Consultant	0	11-3	41
42	Respiratory Therapy Consultant	0	11-3	42
43	Speech Therapy Consultant	0	11-3	43
44	Activity Consultant	22 1,001	11-3	44
45	Social Service Consultant	6 244	11-3	45
46	Other(specify)	0	11-3	46
47		0	11-3	47
48				48
49	TOTAL (lines 35 - 48)	71 \$ 22,749		49

C. CONTRACT NURSES

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

Alden Nursing Center - Lincoln Park
Legal Fee Support
2006

Pg 21A

Legal Fees Reported on Pg 21, Section C:	16,928.00
Less: Collection, estates & other non-allowable legal fees listed on Pg 5, Ln 21	(10,043.00)
Less: Non-allowable legal fees, if any, deducted on Pg 5A	<u>-</u>
Allowable Legal Fees	<u><u>6,885.00</u></u>

Facility Name & ID Number

Alden Nursing Center - Lincoln Park

1/1/2006

Ending:

12/31/2006

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	Climate Serv (repair boiler)	Feb-97	1,644	3									
2	Climate Serv (repair/insulate pip	Apr-97	2,348	3									
3	Climate Serv(insulation-remove c	Jun-97	3,865	3									
4	Climate Serv(install circulating p	Sep-97	2,585	3									
5	Appliance(air conditioning for ki	Aug-97	2,412	3									
6	Great L.P.(remove & install pum	Dec-97	2,595	3									
7	Appliance C.(a/c for kitchen)	May-98	3,702	3									
8	CSI(install ductwork for dryer ex	Sep-98	2,670	3									
9	Custom A.C. (carpeting)	Dec-98	2,940	3									
10	Custom A.C.	Dec-98	192	3									
12	ABC(repair floor and roof)	9/00	10,285	3	2,286								
13	ABC(misc. construction job)	11/00	8,927	3	2,480								
14	GT Mechanical(replace motor)	11/02	1,122	3	374	374	312						
15	Painting > \$1,500 --1999	7/99	11,700	3									
16	Painting > \$1,500 --2000	7/00	6,413	3	1,069								
17													
18													
19	Totals from Page 22 . . .		35,026		343	343	343	343	343	343	343	343	343
20	GRAND TOTALS		98,425		6,552	717	655	343	343	343	343	343	343

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709

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. \$6711
- (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. \$ 15,597 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. \$ 52,560
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. \$ 18,198 Has any meal income been offset against related costs? No Indicate the amount. \$ na
- (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? 0%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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