

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC

0042028 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	93	Skilled (SNF)	93	33,945	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	93	TOTALS	93	33,945	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	26	2,418	17,784	20,228	8
9	SNF/PED					9
10	ICF	654	5,055		5,709	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	680	7,473	17,784	25,937	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.41%

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)

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 8/14/99

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/14/99 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 93 and days of care provided 17,740

Medicare Intermediary ADMINASTAR FEDERAL, INC

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 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	491,419	33,949		525,368	591	525,959		525,959		1
2	Food Purchase		240,927		240,927	(26,805)	214,122	2,839	216,961		2
3	Housekeeping	92,477	27,470		119,947	521	120,468		120,468		3
4	Laundry	47,423	15,561		62,984	152	63,136		63,136		4
5	Heat and Other Utilities			201,253	201,253		201,253	(21,368)	179,885		5
6	Maintenance	44,305	496	93,525	138,326	100	138,426	18,885	157,311		6
7	Other (specify):* Related Party Salary							19,569	19,569		7
8	TOTAL General Services	675,624	318,403	294,778	1,288,805	(25,441)	1,263,364	19,925	1,283,289		8
	B. Health Care and Programs										
9	Medical Director			99,250	99,250		99,250		99,250		9
10	Nursing and Medical Records	1,818,711	118,858	94,090	2,031,659	6,017	2,037,676	(2,960)	2,034,716		10
10a	Therapy	90,116			90,116		90,116		90,116		10a
11	Activities	77,706	4,636	8,719	91,061		91,061		91,061		11
12	Social Services	45,350			45,350		45,350		45,350		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Salary							17,114	17,114		15
16	TOTAL Health Care and Programs	2,031,883	123,494	202,059	2,357,436	6,017	2,363,453	14,154	2,377,607		16
	C. General Administration										
17	Administrative	99,203			99,203		99,203		99,203		17
18	Directors Fees										18
19	Professional Services			835,842	835,842	(3,636)	832,206	(783,041)	49,165		19
20	Dues, Fees, Subscriptions & Promotions			60,593	60,593		60,593	(46,728)	13,865		20
21	Clerical & General Office Expenses	189,729	32,430	74,543	296,702	118	296,820	(15,109)	281,711		21
22	Employee Benefits & Payroll Taxes			392,141	392,141	22,106	414,247	(6,835)	407,412		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,703	7,703		7,703	884	8,587		24
25	Other Admin. Staff Transportation							4,801	4,801		25
26	Insurance-Prop.Liab.Malpractice			97,908	97,908		97,908	8,658	106,566		26
27	Other (specify):* Related Party Salary/Bad Debt			78,373	78,373		78,373	158,883	237,256		27
28	TOTAL General Administration	288,932	32,430	1,547,103	1,868,465	18,588	1,887,053	(678,487)	1,208,566		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,996,439	474,327	2,043,940	5,514,706	(836)	5,513,870	(644,408)	4,869,462		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.

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			52,360	52,360		52,360	208,279	260,639			30
31	Amortization of Pre-Op. & Org.							8,591	8,591			31
32	Interest			343,071	343,071		343,071	398,148	741,219			32
33	Real Estate Taxes							223,428	223,428			33
34	Rent-Facility & Grounds			951,813	951,813		951,813	(951,813)				34
35	Rent-Equipment & Vehicles			7,570	7,570		7,570	17,276	24,846			35
36	Other (specify):* MIP & Amortiz.							59,192	59,192			36
37	TOTAL Ownership			1,354,814	1,354,814		1,354,814	(36,899)	1,317,915			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		949,286	1,296,252	2,245,538	836	2,246,374	(64,846)	2,181,528			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		949,286	1,347,170	2,296,456	836	2,297,292	(64,846)	2,232,446			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,996,439	1,423,613	4,745,924	9,165,976		9,165,976	(746,154)	8,419,822			45

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

Alden of North Shore
 Reporting Period Beginning 1/1/2006
 Reporting Period Ending 12/31/2006

Reclassifications

From Line	To Line	Amount	Description
2	22	(26,805.00)	Employee Meals
		26,805.00	Employee Meals
22	1	(4,699.00)	Uniform
	3	591.00	Uniform
	4	521.00	Uniform
	6	152.00	Uniform
	10	100.00	Uniform
	11	3,217.00	Uniform
	21	0.00	Uniform
		118.00	Uniform
10	39	(836.00)	Oxygen
		836.00	Oxygen
19	10	(3,636.00)	Pathway service
		3,636.00	Pathway service
		0.00	Net

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	(627)	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	(58,375)	30		9
10	Interest and Other Investment Income	(1,257)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,488)	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	(692)	21		17
18	Fines and Penalties	(5,381)	32		18
19	Entertainment	(3,586)	20		19
20	Contributions	(5,303)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,909)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,372)	27		24
25	Fund Raising, Advertising and Promotional	(37,255)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	23	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(40)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (197,262)		\$	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)	(395,839)	Various	34
35	Other- Attach Schedule See Pg 5A	(153,053)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (548,892)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (746,154)		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 NORTH SHORE REHAB & HCC

ID# 0042028

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Valet Cost	\$ (46,713)	21	1
2	Late Fees on Utilities	(6,183)	5	2
3	Late Fees on Telephone	(99)	21	3
4				4
5	Intercompany Interest	(61,409)	32	5
6				6
7	Misc Income(Medical Records)	(843)	10	7
8	Misc Income(Food Rebate)	(628)	2	8
9	Misc Income(Employees Benefits)	(12)	22	9
10	Misc Income (Vending Machine)	(515)	6	10
11	Marketing Manager	(52,117)	21	11
12	Back out % of Employee Benefits for Mktg Mgr	(6,823)	22	12
13	Back out 30.65% of PAC fees from standard ILHCA bills	(1,573)	20	13
14	Vendor Settlement (Comed)	16,559	21	14
15	Vendor Settlement (Comed)	(16,559)	5	15
16	Vendor Settlement (prior year for Legal)	13,874	21	16
17	Vendor Settlement (prior year for Legal)	(13,874)	19	17
18	Add back credit posted for prior yrs' legal costs	7,703	19	18
19	Aj Deprec to correct detail	1,075	30	19
20	Expense Assets < \$2500	15,854	6	20
21	Depreciation adj for assets < \$2500	(769)	30	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	(153,053)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC# 0042028

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,743)	0	0	5,582	0	0	0	0	0	0	0	2,839	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	(22,742)	0	1,374	0	0	0	0	0	0	0	0	(21,368)	5
6	Maintenance	15,339	0	3,800	0	0	0	(254)	0	0	0	0	18,885	6
7	Other (specify):*	0	0	19,569	0	0	0	0	0	0	0	0	19,569	7
8	TOTAL General Services	(10,146)	0	24,743	5,582	0	0	(254)	0	0	0	0	19,925	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	(843)	0	0	398	(2,515)	0	0	0	0	0	0	(2,960)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	17,114	0	0	0	0	0	0	0	0	17,114	15
16	TOTAL Health Care and Programs	(843)	0	17,114	398	(2,515)	0	0	0	0	0	0	14,154	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	(11,080)	5,029	(776,990)	0	0	0	0	0	0	0	0	(783,041)	19
20	Fees, Subscriptions & Promotions	(47,757)	0	1,029	0	0	0	0	0	0	0	0	(46,728)	20
21	Clerical & General Office Expenses	(69,165)	0	15,216	12,940	25,900	0	0	0	0	0	0	(15,109)	21
22	Employee Benefits & Payroll Taxes	(6,835)	0	0	0	0	0	0	0	0	0	0	(6,835)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	884	0	0	0	0	0	0	0	0	884	24
25	Other Admin. Staff Transportation	0	0	4,801	0	0	0	0	0	0	0	0	4,801	25
26	Insurance-Prop.Liab.Malpractice	0	8,546	112	0	0	0	0	0	0	0	0	8,658	26
27	Other (specify):*	(78,372)	0	191,934	16,717	28,604	0	0	0	0	0	0	158,883	27
28	TOTAL General Administration	(213,209)	13,575	(563,014)	29,657	54,504	0	0	0	0	0	0	(678,487)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(224,198)	13,575	(521,157)	35,637	51,989	0	(254)	0	0	0	0	(644,408)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC# 0042028

Report Period Beginning:

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

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

	Capital Expense	PAGES	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	(58,069)	259,212	5,278	0	1,858	0	0	0	0	0	0	208,279	30
31	Amortization of Pre-Op. & Org.	0	7,270	1,321	0	0	0	0	0	0	0	0	8,591	31
32	Interest	(68,047)	415,329	44,203	0	3,477	3,186	0	0	0	0	0	398,148	32
33	Real Estate Taxes	0	219,075	3,055	0	1,298	0	0	0	0	0	0	223,428	33
34	Rent-Facility & Grounds	0	(951,813)	0	0	0	0	0	0	0	0	0	(951,813)	34
35	Rent-Equipment & Vehicles	0	0	17,276	0	0	0	0	0	0	0	0	17,276	35
36	Other (specify):*	0	59,192	0	0	0	0	0	0	0	0	0	59,192	36
37	TOTAL Ownership	(126,116)	8,265	71,133	0	6,633	3,186	0	0	0	0	0	(36,899)	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	(199,056)	(149,822)	284,032	0	0	0	0	0	(64,846)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(199,056)	(149,822)	284,032	0	0	0	0	0	(64,846)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(350,315)	21,840	(450,024)	(163,419)	(91,200)	287,218	(254)	0	0	0	0	(746,154)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6L		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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 951,813	Alden North Shore Associates Limited Partnership		\$	(951,813)	1
2	V	32 Interest Income-RR	3,218	Alden North Shore Associates Limited Partnership			(3,218)	2
3	V	32 Interest Income Misc	185,555	Alden North Shore Associates Limited Partnership			(185,555)	3
4	V	19 Accounting Fees		Alden North Shore Associates Limited Partnership		4,500	4,500	4
5	V	19 Misc Admin Expense		Alden North Shore Associates Limited Partnership		529	529	5
6	V	33 Real Estate Tax		Alden North Shore Associates Limited Partnership		219,075	219,075	6
7	V	26 Property & Liab Insur		Alden North Shore Associates Limited Partnership		8,546	8,546	7
8	V	32 Interest on Mortgage Note		Alden North Shore Associates Limited Partnership		604,102	604,102	8
9	V	36 Mortgage Insur Premium		Alden North Shore Associates Limited Partnership		59,192	59,192	9
10	V	30 Depreciation		Alden North Shore Associates Limited Partnership		259,212	259,212	10
11	V	31 Amortization		Alden North Shore Associates Limited Partnership		7,270	7,270	11
12	V							12
13	V							13
14	Total		\$ 1,140,586			\$ 1,162,426	\$ * 21,840	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	\$ 788,705	Alden Management Services, Inc.		\$ 11,715	\$ (776,990)
16	V	21 General & Admin		Alden Management Services, Inc.		15,216	15,216
17	V	5 Utilities		Alden Management Services, Inc.		1,374	1,374
18	V	6 Maintenance		Alden Management Services, Inc.		3,800	3,800
19	V	24 Auto/Travel/Seminars		Alden Management Services, Inc.		884	884
20	V	26 Insurance		Alden Management Services, Inc.		112	112
21	V	20 Dues & Subscriptions		Alden Management Services, Inc.		1,029	1,029
22	V	30 Depreciation		Alden Management Services, Inc.		5,278	5,278
23	V	31 Amortization		Alden Management Services, Inc.		1,321	1,321
24	V	33 Real Estate Tax		Alden Management Services, Inc.		3,055	3,055
25	V	35 Rent-Equip/Vehicles		Alden Management Services, Inc.		17,276	17,276
26	V	32 Interest		Alden Management Services, Inc.		44,203	44,203
27	V	7 Salaries-General Serv		Alden Management Services, Inc.		19,569	19,569
28	V	15 Salaries-Health Care		Alden Management Services, Inc.		17,114	17,114
29	V	27 Salaries-Gen Admin		Alden Management Services, Inc.		191,934	191,934
30	V	25 Other Admin Travel		Alden Management Services, Inc.		4,801	4,801
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 788,705			\$ 338,681	\$ * (450,024)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary Consultant	\$	Prism Health Care Services, Inc.		\$	\$	15
16	V	7 Dietary Sal & Wages		Prism Health Care Services, Inc.				16
17	V	2 Tube Feeding		Prism Health Care Services, Inc.		5,582	5,582	17
18	V	10 Equipment Rental - Patient Care	3,060	Prism Health Care Services, Inc.		3,458	398	18
19	V	39 Ancillary Supplies	249,436	Prism Health Care Services, Inc.		50,380	(199,056)	19
20	V	39 Ancillary Vent Rentals		Prism Health Care Services, Inc.				20
21	V	27 Gen'l & Admin Salaries		Prism Health Care Services, Inc.		16,717	16,717	21
22	V	21 Gen'l & Admin Expenses		Prism Health Care Services, Inc.		12,940	12,940	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		\$ 252,496			\$ 89,077	\$ * (163,419)	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 <u>Drugs</u>	\$ 367,191	<u>Forum Extended Care Services II, Inc.</u>		\$ 515,556	\$ 148,365
16	V	10 <u>House Stock</u>	5,766	<u>Forum Extended Care Services II, Inc.</u>		5,198	(568)
17	V	39 <u>IV</u>	332,607	<u>Forum Extended Care Services II, Inc.</u>		34,431	(298,176)
18	V	39 <u>Wound Care</u>	52	<u>Forum Extended Care Services II, Inc.</u>		41	(11)
19	V	21 <u>Gen'l & Admin</u>		<u>Forum Extended Care Services II, Inc.</u>		25,900	25,900
20	V	32 <u>Interest</u>		<u>Forum Extended Care Services II, Inc.</u>		3,477	3,477
21	V	33 <u>Real Estate Tax</u>		<u>Forum Extended Care Services II, Inc.</u>		1,298	1,298
22	V	30 <u>Depreciation</u>		<u>Forum Extended Care Services II, Inc.</u>		1,858	1,858
23	V	27 <u>Gen'l & Admin Salary</u>		<u>Forum Extended Care Services II, Inc.</u>		28,855	28,855
24	V	10 <u>Pharmacy Consulting</u>	16,452	<u>Forum Extended Care Services II, Inc.</u>		14,505	(1,947)
25	V	27 <u>Employee Vacin</u>	1,151	<u>Forum Extended Care Services II, Inc.</u>		900	(251)
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		\$ 723,219			\$ 632,019	\$ * (91,200)

* 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	\$ 1,241,259	Community Physical Therapy & Associates, Ltd.		\$ 1,525,291	\$ 284,032	15
16	V	32 Interest				3,186	3,186	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		\$ 1,241,259			\$ 1,528,477	\$ * 287,218	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Repairs & Maintenance	\$ 16,615	Alden Bennett Construction Company, Inc.		\$ 16,361	\$ (254)
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		\$ 16,615			\$ 16,361	\$ * (254)

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

Facility Name & ID Number

ALDEN NURSING CENTER - NORTH SHORE

004-2028

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 Lincoln Park	Chicago
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
ANC Waterford	Aurora
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
Alden 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

**INVESTOR LIST AND PERCENTAGES
AS OF DECEMBER 31, 2006**

6L

NAME		16,500
		NS
FLOYD A. SCHLOSSBERG		22.00
Lauren Magnusson		1.67
JOAN/SAM CARL		7.50
AMI PISSETZKY		1.00
ROBERT MOLITOR		0.50
MARY CHELOTTI-SMITH		0.50
LAUREN & TERRY MAGNUSSION		1.00
Others		65.84
TOTALS		100.00

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC # 0042028 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	27.00	136,265	0.928	2.32	Salary	\$ 3,235	27-2	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	1.00	79,869	0.928	2.32	Salary	1,896	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	51,815	0.928	2.32	Salary	1,230	7-Jul	3
4	Joan Carl d.	Secretary	Vice-President	7.50	136,265	0.928	2.32	Salary	3,235	27-2	4
5	see others attached on page 7A			2.00	439,077	0.928	2.32	Salary	10,423		5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 20,019		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 NORTH SHORE REHAB & # 0042028 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	2	3	4	5	6		7		8		
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1								\$		1	
2	Summary...									2	
3	Ami Pissetzki	finance relations	invest/bank	1.00	136,265	0.928	2.32	Salary	3,235	27-7	3
4	Bob Molitor	Vp of Operations	operations	0.50	151,406	0.928	2.32	Salary	3,594	27-7	4
5	Mary Chelotti Smith	In-house counsel	legal advis.	0.50	151,406	0.928	2.32	Salary	3,594	27-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12					439,077						12
13								TOTAL	\$ 10,423		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 NORTH SHORE REHAB & HCC

0042028

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 NORTH SHORE REHAB & HCC

0042028

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	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	\$42,694.00	08/01/05	\$ 8,388,000	\$ 8,306,111	07/31/45	5.4000	\$ 432,748	1								
2	Cambridge		X	Oper Loss Loan	\$16,822.00	08/01/03	3,098,700	2,994,829	08/31/39	5.6900	171,354	2								
3	Bank Leumi		X	LOC	\$15,000.00	06/01/05	1,200,000	1,184,343	06/01/07	Varies	90,726	3								
4												4								
5												5								
Working Capital																				
6	Related Party-AMS	X		Working Capital							44,203	6								
7	Related Party-CPT	X		Working Capital							3,186	7								
8	Related Party-FECH	X		Working Capital							3,477	8								
9	TOTAL Facility Related				\$74,516.00		\$ 12,686,700	\$ 12,485,283			\$ 745,694	9								
B. Non-Facility Related*																				
10												10								
11	Offset interest expense with NS Assoc's interest income										(3,218)	11								
12	Offset interest expense with Corp's interest income										(1,257)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (4,475)	14								
15	TOTALS (line 9+line14)						\$ 12,686,700	\$ 12,485,283			\$ 741,219	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 59,192 Line # 36* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	214,300	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.)		\$	213,475	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(825)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	219,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	219,075	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	129,328	8
	2002	190,237	9
	2003	207,104	10
	2004	208,042	11
	2005	213,475	12

2006 Accrual is based on 103% of 2005 paid tax invoices

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 NORTH SHORE REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042028

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>10-28-429-015-0000</u>	<u>Nursing Home Facility</u>	\$ <u>2,817.46</u>	\$ <u>2,817.46</u>
2. <u>10-28-429-016-0000</u>	<u>Nursing Home Facility</u>	\$ <u>2,073.55</u>	\$ <u>2,073.55</u>
3. <u>10-28-429-017-0000</u>	<u>Nursing Home Facility</u>	\$ <u>5,738.02</u>	\$ <u>5,738.02</u>
4. <u>10-28-429-018-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,795.38</u>	\$ <u>20,795.38</u>
5. <u>10-28-429-019-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,805.79</u>	\$ <u>20,805.79</u>
6. <u>10-28-429-020-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,656.92</u>	\$ <u>20,656.92</u>
7. <u>10-28-429-021-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,656.92</u>	\$ <u>20,656.92</u>
8. <u>10-28-429-022-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,638.65</u>	\$ <u>20,638.65</u>
9. <u>10-28-429-023-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,619.95</u>	\$ <u>20,619.95</u>
10. <u>10-28-429-024-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,604.31</u>	\$ <u>20,604.31</u>
	TOTALS	\$ <u>155,406.95</u>	\$ <u>155,406.95</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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN NORTH SHORE REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042028

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 2000 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 2000.

(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>10-28-429-025-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,604.31</u>	\$ <u>20,604.31</u>
2. <u>10-28-429-026-0000</u>	<u>Nursing Home Facility</u>	\$ <u>20,604.31</u>	\$ <u>20,604.31</u>
3. <u>10-28-429-027-0000</u>	<u>Nursing Home Facility</u>	\$ <u>16,859.60</u>	\$ <u>16,859.60</u>
4. <u>Support Attached (pages)</u>	<u>Related Party-Alden Management</u>	\$ <u>131,720.00</u>	\$ <u>3,055.00</u>
5. <u>Support Attached (pages)</u>	<u>Related Party-Forum</u>	\$ <u>14,554.00</u>	\$ <u>1,298.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>204,342.22</u>	\$ <u>62,421.22</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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC

0042028

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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	<u>SNF</u>	<u>34,483</u>	<u>1997</u>	<u>\$ 955,797</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	34,483		\$ 955,797	3

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC

0042028

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	93		1999	1999	6,782,967	195,977	40	169,574	(26,403)	1,187,018	6
7											7
8											8
	Improvement Type**										
9	draper corp-electric screen		1999		1,252	125	10	125		918	9
10	dakota wiring & comm.-wiring for cable tv		1999		2,500	250	10	250		1,813	10
11	climate serv-repair compressor		1999		1,990	133	15	133		904	11
12	fcj cable-install cable		1999		1,254	125	10	125		898	12
13	ABC-install tiles/repair		2000		4,011	267	15	267		1,827	13
14	ABC-mainten-various/construction		2000		5,000	500	10	500		3,417	14
15	ABC-mainten-various/construction		2000		10,000	1,000	10	1,000		6,750	15
16	ABC-mainten-various/construction		2000		10,000	1,000	10	1,000		6,667	16
17	new horizons-phone system		2000		5,744	574	10	574		3,877	17
18	new horizons-phone system & cable		2000		2,784	278	10	278		1,856	18
19	new horizons-phone system		2000		3,742	374	10	374		2,494	19
20	dfs contract.-lawn sprinkler system		2000		1,611	107	15	107		698	20
21	ABC-misc construction work		2000		5,347	891	5	891		5,347	21
22	ABC-misc construction work		2000		13,118	2,405	5	2,405		13,118	22
23	ABC-misc construction work (12/31/01 finished-begin exp '02)		2001		3,361	336	10	336		1,680	23
24	Laport (walk off mat carpet/floor covering)		2001		3,548	591	5	591		3,548	24
25	The Floor Source (PT carpet/floor covering)		2001		1,576	289	5	289		1,576	25
26	ABC-beds/bedside cabinets/washers/dryers/bookcases/wallcover		2001		289,721	19,315	15	19,315		115,889	26
27	New Horizon (phone system)		2001		1,256	126	10	126		649	27
28	ABC-misc construction work		2002		19,580	1,305	15	1,305		6,526	28
29	ABC-misc construction work		2002		6,706	447	15	447		2,235	29
30	ABC-misc construction work		2002		16,368	1,091	15	1,091		5,456	30
31	ABC-misc construction work		2003		2,116	212	10	212		847	31
32	GT Mechanical-repair exhaust fans		2003		6,080	608	10	608		2,229	32
33	EWS-repair opxyen alarm ssystem		2003		2,054	411	5	411		1,438	33
34	ABC-parking lot upgrades		2003		7,538	753	10	753		2,638	34
35	ABC-parking lot repairs		2003		2,943	589	5	589		2,061	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.

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC

0042028

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	GT Mechanical-thermostat equip	2004	1,693	169	10	169		\$ 508	37
38	ABC-repair sewer	2004	19,580	1,958	10	1,958		5,385	38
39	GT Mechanical-misc repairs	2004	1,442	288	5	288		769	39
40	GT Mechanical-replace pump	2004	2,496	499	5	499		1,289	40
41	GT Mechanical-misc repairs	2004	614	123	5	123		318	41
42	ABC-bath,plumb. Upgrade	2004	1,813	181	10	181		468	42
43	ABC-painting supplies	2004	1,258	252	5	252		629	43
44	GT Mechanical-Electric improvement	2004	917	92	10	92		214	44
45	ABC-plumbing/misc. repairs	2004	3,971	397	10	397		893	45
46									46
47	TopNotch-motor drive repair	2004	3,139	314	10	314		654	47
48	ABD- carpet repairs	2004	4,943	494	10	494		1,029	48
49	ABC-misc repairs	2004	2,783	398	7	398		1,094	49
50	ABC parking lot improve.	2004	16,008	1,601	10	1,601		3,602	50
51									51
52	ABC-Cabinetry	2005	4,393	183	15	183		344	52
53	Patten CAT-Repair Generator	2005	2,074	78	20	78		156	53
54	GT Mechanical-No AC Water/Temp Low	2005	1,340	89	10	89		299	54
55	GT Mechanical-3 new motors, motor brackets, and fan blades	2005	4,497	187	10	187		508	55
56	ABC-misc construction work	2005	(19,580)	(1,305)	15	(1,305)		(6,526)	56
57	ABC-misc construction work	2005	(6,706)	(447)	15	(447)		(2,235)	57
58									58
59	ABC-Patten Repair Generator	2006	2,898	242	10	242		242	59
60	GT Mech-Repaired East Chiller	2006	2,529	190	10	190		190	60
61	ABC-2nd Floor Nurses Station	2006	4,312	216	15	216		216	61
62	Repaired AC	2006	7,776	194	10	194		194	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,293,194	\$ 236,471		\$ 210,068	\$ (26,403)	\$ 1,409,452	70

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

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC

0042028

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,293,194	\$ 236,471		\$ 210,068	\$ (26,403)	\$ 1,409,452	1
2									2
3	Related Party-Forum Prof Center Building:	1980	11,260		15			11,260	3
4	Leasehold Improvement-Remodeling	1980	17,639		20			17,639	4
5	Leasehold Improvement-Remodeling	1987	912		13			912	5
6	Leasehold Improvement-Tenant Improvement	1988	14,634		10			14,634	6
7	Leasehold Improvement-AMS Remodel	1994	3,269	204	16	204		2,453	7
8	Leasehold Improvement-Roof	1996	1,153	72	16	72		789	8
9	Leasehold Improvement-Build.Improv.	2000	89		3			89	9
10	Leasehold Improvement-Asphalting	2001	157	16	10	16		81	10
11	Leasehold Improvement-DAI	2002	681	77	7	77		324	11
12	Leasehold Improvement-Bathrooms	2003	1,672	167	10	167		669	12
13	Leasehold Improvement-Suite Renovation	2004	2,071	360	7	360		835	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	1980	73		23			73	14
15	Leasehold Improvement-Add-on Improvement, fixture base	2001	126	6	5	6		126	15
16	Leasehold Improvement-Add-on Improvement, lighting base								16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:	1993	6,060		7			6,060	26
27	Leasehold Improvement-Remodeling	2002	4,961	709	7	709		2,746	27
28	Leasehold Improvement-Remodeling	2003	5,189	741	7	741		2,856	28
29	Leasehold Improvement-Remodeling								29
30									30
31									31
32	Forum Extended Care, LLC-building/building improv	1999	12,928	306	30	306		2,445	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,376,068	\$ 239,129		\$ 212,726	\$ (26,403)	\$ 1,473,443	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	\$ 559,346	\$ 74,698	\$ 42,725	\$ (31,972)	Various	\$ 506,464	71
72	Current Year Purchases	53,390	3,170	3,170		Various	1,250	72
73	Fully Depreciated Assets	87,277	1,905	1,905		Various	87,277	73
74								74
75	TOTALS	\$ 700,013	\$ 79,773	\$ 47,800	\$ (31,972)		\$ 594,992	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus-van	01 Bus	01	\$ 49,826	\$	\$	\$	5	\$ 49,826	76
77	Related Party-AMS	Various/Bus/Autos	1998-2004	4,817	113	113		3	4,787	77
78										78
79										79
80	TOTALS			\$ 54,643	\$ 113	\$ 113	\$		\$ 54,613	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,086,521	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 319,015	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,639	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (58,375)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,123,048	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,790 Description: Copier Machine Lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related Party- AMS</u>		\$ <u>#####</u>	\$ <u>17,276</u>	17
18	<u>Various Auto Lease</u>		<u>231.67</u>	<u>2,780</u>	18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>20,056</u>	21

10. Effective dates of current rental agreement:

Beginning 03/01/2000

Ending 12/31/2039

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

Fiscal Year Ending Annual Rent

12. /2007 \$ Varies

13. /2008 \$ Varies

14. /2009 \$ Varies

* 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	\$		\$ 449,578	\$		\$ 449,578	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			33,922			33,922	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			758,003			758,003	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 prescrpts				515,556		515,556	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Pg 16A				284,032	140,437		424,469	13
14	TOTAL			\$		\$ 1,525,535	\$ 655,993		\$ 2,181,528	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	\$449,577.83
2. ST	39-3	To Col 5	33,922.16
3.			
4. PT	39-3	To Col 5	758,002.55
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			367,190.78
Manual Input from Related Party- Forum Drugs			148,365.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	515,555.78
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00
Total Exceptional Care (Line 12, Col 8)			0.00
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	284,032.00
Other			636,845.30
Manual Input: Related Party - Pyramic			(199,057.00)
Manual Input: Related Party FECII - I.V			(298,176.00)
Manual Input: Related Party FECII - Wound Care			(11.00)
Oxygen, from reclass worksheet			836.00
13. Col 6: Supplies Total		To Col 6	140,437.30
13. Total Line 13, Column 8			140,437.30
14. Total			2,181,527.62

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC

0042028

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	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>88,000</u>)	1,198,117	1,198,117	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,994,829	5
6	Prepaid Insurance		45,716	6
7	Other Prepaid Expenses	2,277	2,277	7
8	Accounts Receivable (owners or related parties)	42,961	42,961	8
9	Other(specify): <u>Due from 3rd parties</u>	32,785	32,785	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,276,140	\$ 4,316,685	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		955,797	13
14	Buildings, at Historical Cost		7,839,086	14
15	Leasehold Improvements, at Historical Cost	499,855	499,855	15
16	Equipment, at Historical Cost	174,401	1,143,073	16
17	Accumulated Depreciation (book methods)	(330,468)	(2,215,197)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,343	307,074	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,343)	(43,573)	20
21	Restricted Funds		189,945	21
22	Other Long-Term Assets (specify): <u>Due to Affiliates</u>	3,282,177	3,243,716	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,625,965	\$ 11,919,776	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,902,105	\$ 16,236,461	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,042,450	\$ 1,016,260	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	136,344	136,344	28
29	Short-Term Notes Payable	1,184,343	1,282,025	29
30	Accrued Salaries Payable	292,957	292,957	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,479	15,479	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,924	228,824	32
33	Accrued Interest Payable		51,578	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Exp, IDPA, Misc</u>	225,656	476,356	36
37	<u>Due to Affiliates</u>	1,099,040	1,099,040	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,005,193	\$ 4,598,863	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,962,543	2,335,762	39
40	Mortgage Payable		11,203,258	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,962,543	\$ 13,539,020	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,967,736	\$ 18,137,883	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,065,631)	\$ (1,901,422)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,902,105	\$ 16,236,461	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,408,363)	1
2	Restatements (describe):		2
3	Prior Year Adjustment	(14,347)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,422,710)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,357,079	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)	\$ 1,357,079	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,065,631)	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	\$ 10,386,980	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,386,980	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,080	6
7	Oxygen	3,010	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 73,090	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	130	12
13	Barber and Beauty Care	4,667	13
14	Non-Patient Meals	627	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,052	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	611	19
20	Radiology and X-Ray		20
21	Other Medical Services	31,593	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,680	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,257	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,257	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG 19A	5,697	28
28a	Gain on Sale of Assets	6,351	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,048	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,523,055	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,288,805	31
32	Health Care	2,357,436	32
33	General Administration	1,868,465	33
	B. Capital Expense		
34	Ownership	1,354,814	34
	C. Ancillary Expense		
35	Special Cost Centers	2,245,538	35
36	Provider Participation Fee	50,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,165,976	40
41	Income before Income Taxes (line 30 minus line 40)**	1,357,079	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,357,079	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Done Yet 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.

PA Pg 19 P & L
For the Thirteen Months Ending December 31, 2006

Column 1
Amount

Page 19A

Room Service(Private Only)	2,829.15
Misc Income(Medical Records)	843.75
Misc Income(Food Rebate)	627.94
Misc Income(Employees Benefits)	12.00
Misc Income (Vending Machine)	514.69
Adjustment to Prior year expense	868.85
	0.00
	0.00

	0.00 5,696.38
	=====

Facility Name & ID Number **ALDEN NORTH SHORE REHAB & HCC**

0042028

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	2,092	2,092	\$ 76,954	\$ 36.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,274	25,631	791,410	30.88	3
4	Licensed Practical Nurses	4,311	4,540	106,237	23.40	4
5	CNAs & Orderlies	53,632	55,867	732,424	13.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,080	2,080	27,354	13.15	8
9	Activity Director	2,080	2,080	35,457	17.05	9
10	Activity Assistants	3,864	4,114	42,249	10.27	10
11	Social Service Workers	2,080	2,080	45,350	21.80	11
12	Dietician					12
13	Food Service Supervisor	2,298	2,298	62,583	27.23	13
14	Head Cook	6,453	6,453	96,473	14.95	14
15	Cook Helpers/Assistants	29,686	31,668	332,364	10.50	15
16	Dishwashers					16
17	Maintenance Workers	1,919	1,919	44,305	23.09	17
18	Housekeepers	9,626	10,256	92,477	9.02	18
19	Laundry	5,580	5,901	47,423	8.04	19
20	Administrator	2,064	2,080	86,389	41.53	20
21	Assistant Administrator	400	400	12,814	32.04	21
22	Other Administrative	6,966	6,966	196,100	28.15	22
23	Office Manager	1,800	1,824	27,504	15.08	23
24	Clerical	3,296	3,363	28,886	8.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,512	2,512	78,636	31.30	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Unit Director</u>	2,080	2,080	33,050	15.89	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,093	176,204	\$ 2,996,439 *	\$ 17.01	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	8271/Monthly	99,250	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	186/ Monthly	2,232	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	177/ Monthly	2,125	11-3	44
45	Social Service Consultant	4	1,088	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	\$ 104,695		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Illarde	Administrator		\$ 86,389	Workers' Compensation Insurance	\$ 70,294	IDPH License Fee	\$	
Loraine Mira	Asst Admin		12,814	Unemployment Compensation Insurance	32,248	Advertising: Employee Recruitment	1,718	
				FICA Taxes	215,814	Health Care Worker Background Check	320	
				Employee Health Insurance	62,909	(Indicate # of checks performed)		
				Employee Meals	26,805	Patient Background Checks	4,980	
				Illinois Municipal Retirement Fund (IMRF)*		II Health Care Assoc	5,241	
						Surety Bond Fee	300	
				Mktg Manager Benefit Deduction	(6,823)	Related party - AMS	1,029	
				Dental, Life	1,318	Secretary of State	277	
				Emp Relations, Misc	1,949	Chicago SunTimes		
				Tuition Reim, Drug Test, 401K, Vaccinations	2,898	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,203	TOTAL (agree to Schedule V, line 22, col.8)		\$ 13,865		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Auto/Gas	6,306
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Related Party-AMS	884
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount				Training Reimbursement	
Alden Management	Management Fees		\$ 788,705				Leadership Training	
Barry H Greenburg, Ken Fisch	Legal Fees Non Collections		1,339					
Pathway	clinical consultants		3,636				Entertainment Expense	
Cambridge	Financing Fees Title Service		12,492				(agree to Sch. V, line 24, col. 8)	
SMS	Billing Consultant		1,662				\$ 8,587	
BDO	Accounting Fees		20,924					
Ken Fisch	Legal Fees Collections		3,941					
Neal, Gerber, & Eisenberg	Union Organization		2,850					
MediCom	billing consult.		293					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 835,842	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	painting>\$1500 for 2000	7/00	\$ 2,176	3	\$ 363	\$ 0	\$	\$	\$	\$	\$	\$								
2	GT Mechanical-repair ho	10/03	2,258	3	188	753	753	564	0	0										
3	ABC-repair water booster	6/03	2,209	3	429	736	736	308	0	0										
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 6,643		\$ 980	\$ 1,489	\$ 1,489	\$ 872	\$	\$	\$	\$								

Facility Name & ID Number ALDEN NORTH SHORE REHAB & HCC

0042028

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. II. Health Care Assn. \$5,134
- (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. \$ 15,463 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. \$ 50,918
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. \$ 26,805 Has any meal income been offset against related costs? None 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? _____
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? Yes
Firm Name: Reznick Group, LP 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