

		FOR BHF USE				

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

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0047191

**Facility Name:** ALDEN SPRINGS

**Address:** 207 EAST ARMY TRAIL ROAD BLOOMINGDALE 60108  
 Number City Zip Code

**County:** DUPAGE

**Telephone Number:** (630) 523-5783 **Fax #** (630) 523-5787

**HFS ID Number:** 83-0375144

**Date of Initial License for Current Owners:** 9/25/06

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** STEVEN M. KROLL **Telephone Number:** (773) 286-3883

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/13/06 to 4/30/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven Kroll as agent for Alden Springs, Inc.</u>	
	(Title) <u>Chief Financial Officer of The Alden Group, Ltd.</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ALDEN SPRINGS

# 0047191 Report Period Beginning: 10/13/06 Ending: 4/30/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	3,200	6
7	16	TOTALS	16	3,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	898			898
14	TOTALS	898			898

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 28.06%

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

None (Do not include bed-hold days in Section B.)

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

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

None

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

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

YES  NO

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

YES  NO

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

Date started 10/13/06

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number ALDEN SPRINGS # 0047191 Report Period Beginning: 10/13/06 Ending: 4/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	9,402	139		9,541	51	9,592		9,592		1
2	Food Purchase		14,822		14,822	(357)	14,465	(1,832)	12,633		2
3	Housekeeping		4,403		4,403	33	4,436		4,436		3
4	Laundry		926		926	9	935		935		4
5	Heat and Other Utilities			9,712	9,712	4	9,716	(118)	9,598		5
6	Maintenance		50	15,885	15,935		15,935	138	16,073		6
7	Other (specify):* <b>Related Party Salary</b>							414	414		7
8	<b>TOTAL General Services</b>	9,402	20,340	25,597	55,339	(260)	55,079	(1,398)	53,681		8
	<b>B. Health Care and Programs</b>										
9	Medical Director		7,359	750	8,109		8,109		8,109		9
10	Nursing and Medical Records	121,434		224	121,658	219	121,877	(68)	121,809		10
10a	Therapy					2,664	2,664	(2,006)	658		10a
11	Activities			5,399	5,399	6	5,405		5,405		11
12	Social Services	14,889			14,889		14,889		14,889		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Related Party Salary</b>							362	362		15
16	<b>TOTAL Health Care and Programs</b>	136,323	7,359	6,373	150,055	2,889	152,944	(1,712)	151,232		16
	<b>C. General Administration</b>										
17	Administrative	5,938			5,938		5,938		5,938		17
18	Directors Fees										18
19	Professional Services			13,593	13,593		13,593	(13,019)	574		19
20	Dues, Fees, Subscriptions & Promotions			2,426	2,426		2,426	(1,614)	812		20
21	Clerical & General Office Expenses		2,637	8,476	11,113	16	11,129	(220)	10,909		21
22	Employee Benefits & Payroll Taxes			20,929	20,929	19	20,948		20,948		22
23	Inservice Training & Education										23
24	Travel and Seminar			791	791		791	19	810		24
25	Other Admin. Staff Transportation							102	102		25
26	Insurance-Prop.Liab.Malpractice			9,682	9,682		9,682	949	10,631		26
27	Other (specify):* <b>Related Party Salary</b>			928	928		928	3,156	4,084		27
28	<b>TOTAL General Administration</b>	5,938	2,637	56,825	65,400	35	65,435	(10,627)	54,808		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	151,663	30,336	88,795	270,794	2,664	273,458	(13,737)	259,721		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 SPRINGS

#0047191

Report Period Beginning:

10/13/06

Ending:

4/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			1,766	1,766		1,766	37,808	39,574			30
31	Amortization of Pre-Op. & Org.							28	28			31
32	Interest			2,704	2,704		2,704	59,049	61,753			32
33	Real Estate Taxes							2,110	2,110			33
34	Rent-Facility & Grounds			80,493	80,493		80,493	(79,178)	1,315			34
35	Rent-Equipment & Vehicles			96	96		96	365	461			35
36	Other (specify):* <b>MIP &amp; Amortiz.</b>											36
37	<b>TOTAL Ownership</b>			85,059	85,059		85,059	20,182	105,241			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,214	2,664	3,878	(2,664)	1,214	(1,147)	67			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,864	41,864		41,864		41,864			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,214	44,528	45,742	(2,664)	43,078	(1,147)	41,931			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	151,663	31,550	218,382	401,595		401,595	5,298	406,893			45

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

Reclassifications Pg 3 and 4, Column 5

From Line	To Line	Amount	Description
	22	-338.22	Uniforms
	1	51.45	Uniforms
	3	33.01	Uniforms
	4	9.11	Uniforms
	6	4.30	Uniforms
	10	219.02	Uniforms
	11	5.78	Uniforms
	21	15.55	Uniforms
	2	-357	Employee Meal
	22	357	Employee Meal
	39	-2664	PT/OT/ST
	10A	2664	PT/OT/ST

Facility Name & ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning: 10/13/06

Ending: 4/30/07

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,177)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(147)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(373)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(928)	27		24
25	Fund Raising, Advertising and Promotional	(1,489)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (4,114)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	15,334	Various	34
35	Other- Attach Schedule See Pg 5A	(5,922)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 9,412		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 5,298		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## ALDEN SPRINGS

ID# 0047191

Report Period Beginning: 10/13/06

Ending: 4/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Late Fees on Utilities	\$ (147)	5	1
2	Intercompany Interest	(2,704)	32	2
3	Bank Charges on related party	(215)	21	3
4	Real Estate Tax Adj	(2,856)	33	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,922)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning:

10/13/06

Ending:

4/30/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	(1,832)	0	0	0	0	0	0	0	(1,832)	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	(147)	0	29	0	0	0	0	0	0	0	0	(118)	5
6	Maintenance	0	0	80	0	0	0	58	0	0	0	0	138	6
7	Other (specify):*	0	0	414	0	0	0	0	0	0	0	0	414	7
8	<b>TOTAL General Services</b>	<b>(147)</b>	<b>0</b>	<b>523</b>	<b>(1,832)</b>	<b>0</b>	<b>0</b>	<b>58</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,398)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(68)	0	0	0	0	0	0	(68)	10
10a	Therapy	0	0	0	0	0	(2,006)	0	0	0	0	0	(2,006)	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	362	0	0	0	0	0	0	0	0	362	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>362</b>	<b>0</b>	<b>(68)</b>	<b>(2,006)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,712)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(373)	92	(12,738)	0	0	0	0	0	0	0	0	(13,019)	19
20	Fees, Subscriptions & Promotions	(1,636)	0	22	0	0	0	0	0	0	0	0	(1,614)	20
21	Clerical & General Office Expenses	(1,392)	806	322	16	28	0	0	0	0	0	0	(220)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	19	0	0	0	0	0	0	0	0	19	24
25	Other Admin. Staff Transportation	0	0	102	0	0	0	0	0	0	0	0	102	25
26	Insurance-Prop.Liab.Malpractice	0	947	2	0	0	0	0	0	0	0	0	949	26
27	Other (specify):*	(928)	0	4,058	21	5	0	0	0	0	0	0	3,156	27
28	<b>TOTAL General Administration</b>	<b>(4,329)</b>	<b>1,845</b>	<b>(8,213)</b>	<b>37</b>	<b>33</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(10,627)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(4,476)</b>	<b>1,845</b>	<b>(7,328)</b>	<b>(1,795)</b>	<b>(35)</b>	<b>(2,006)</b>	<b>58</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,737)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning:

10/13/06 Ending:

4/30/07

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	0	34,339	2,566	0	903	0	0	0	0	0	0	37,808	30
31	Amortization of Pre-Op. & Org.	0	0	28	0	0	0	0	0	0	0	0	28	31
32	Interest	(2,704)	60,807	934	0	5	7	0	0	0	0	0	59,049	32
33	Real Estate Taxes	(2,856)	4,899	65	0	2	0	0	0	0	0	0	2,110	33
34	Rent-Facility & Grounds	0	(79,178)	0	0	0	0	0	0	0	0	0	(79,178)	34
35	Rent-Equipment & Vehicles	0	0	365	0	0	0	0	0	0	0	0	365	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,560)</b>	<b>20,867</b>	<b>3,958</b>	<b>0</b>	<b>910</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>20,182</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(1,147)	0	0	0	0	0	0	0	(1,147)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,147)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,147)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(10,036)</b>	<b>22,712</b>	<b>(3,370)</b>	<b>(2,942)</b>	<b>875</b>	<b>(1,999)</b>	<b>58</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,298</b>	<b>45</b>

Facility Name & ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning:

10/13/06

Ending:

4/30/07

**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
<u>THE ALDEN GROUP, LTD</u>	<u>100</u>	<u>See Pg 6K</u>		<u>See Pg 6K</u>		

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	<u>34 Rent Income</u>	\$ <u>79,178</u>	<u>ALDEN TRAILS II, LLC</u>	<u>100.00%</u>	\$	\$ <u>(79,178)</u>	1
2	V	<u>32 Interest Income</u>		<u>ALDEN TRAILS II, LLC</u>				2
3	V	<u>19 Professional Fees</u>		<u>ALDEN TRAILS II, LLC</u>		<u>92</u>	<u>92</u>	3
4	V	<u>21 Dues+Subscriptions</u>		<u>ALDEN TRAILS II, LLC</u>		<u>806</u>	<u>806</u>	4
5	V	<u>33 Real Estate Tax Exp</u>		<u>ALDEN TRAILS II, LLC</u>		<u>4,899</u>	<u>4,899</u>	5
6	V	<u>26 General Insurance Exp</u>		<u>ALDEN TRAILS II, LLC</u>		<u>947</u>	<u>947</u>	6
7	V	<u>32 Interest Harris</u>		<u>ALDEN TRAILS II, LLC</u>		<u>60,807</u>	<u>60,807</u>	7
8	V	<u>30 Depreciation Exp</u>		<u>ALDEN TRAILS II, LLC</u>		<u>34,339</u>	<u>34,339</u>	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ <u>79,178</u>			\$ <u>101,890</u>	\$ * <u>22,712</u>	14

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

Facility Name & ID Number ALDEN SPRINGS# 0047191Report Period Beginning: 10/13/06Ending: 4/30/07

## 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	\$ 12,986	Alden Management Services, Inc	0.00%	\$ 248	\$ (12,738)	15
16	V	21 Gen'l & Admin		Alden Management Services, Inc		322	322	16
17	V	5 Utilities		Alden Management Services, Inc		29	29	17
18	V	6 Rep & Maint		Alden Management Services, Inc		80	80	18
19	V	24 Travel & Seminar		Alden Management Services, Inc		19	19	19
20	V	25 Other Admin Travel		Alden Management Services, Inc		102	102	20
21	V	26 Forum Allocated Insurance		Alden Management Services, Inc		2	2	21
22	V	20 Dues, Subscriptions		Alden Management Services, Inc		22	22	22
23	V	30 Depreciation		Alden Management Services, Inc		2,566	2,566	23
24	V	31 Amortization		Alden Management Services, Inc		28	28	24
25	V	33 Real Estate Taxes		Alden Management Services, Inc		65	65	25
26	V	34 Rent		Alden Management Services, Inc				26
27	V	35 Rent-Equip & Vehic		Alden Management Services, Inc		365	365	27
28	V	32 Interest		Alden Management Services, Inc		934	934	28
29	V	7 Gen'l Serv Salary		Alden Management Services, Inc		414	414	29
30	V	15 Health Care Salary		Alden Management Services, Inc		362	362	30
31	V	27 G&A Salaries		Alden Management Services, Inc		4,058	4,058	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 12,986			\$ 9,616	\$ * (3,370)	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	Supplies	\$ 1,208	Prism Health Care Services, Inc.	0.00%	\$ 61	\$ (1,147)	15
16	V	2	Tube Feeding	6,870	Prism Health Care Services, Inc.		5,038	(1,832)	16
17	V	27	G+A Salaries		Prism Health Care Services, Inc.		21	21	17
18	V	21	G+A		Prism Health Care Services, Inc.		16	16	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			\$ 8,078			\$ 5,136	\$ * (2,942)	39

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

Facility Name & ID Number ALDEN SPRINGS# 0047191Report Period Beginning: 10/13/06Ending: 4/30/07

## 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	\$	Forum Extended Care Services II, Inc.	0.00%	\$	\$	15	
16	V	39	IV		Forum Extended Care Services II, Inc.				16	
17	V	39	Wound Care		Forum Extended Care Services II, Inc.				17	
18	V	10	House Stock	418	Forum Extended Care Services II, Inc.		376	(42)	18	
19	V	10	Pharm Consult	224	Forum Extended Care Services II, Inc.		198	(26)	19	
20	V	27	Employ Vaccin	121	Forum Extended Care Services II, Inc.		96	(25)	20	
21	V	27	G&A Salary				30	30	21	
22	V	21	Gen'l & Admin				28	28	22	
23	V	32	Interest				5	5	23	
24	V	33	Real Estate Tax				2	2	24	
25	V	30	Depreciation				903	903	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		\$ 763				\$ 1,638	\$ *	875	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	10A	Therapy	\$ 2,793	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 787	\$ (2,006)	15
16	V	32	Interest				7	7	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			\$ 2,793			\$ 794	\$ * (1,999)	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+Mainten	\$ 3,742	Alden Bennett Construction Company, Inc.	0.00%	\$ 3,800	\$ 58	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 3,742			\$ 3,800	\$ *	58 39

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

STATE OF ILLINIOS

Facility Name & ID Number **Alden Springs Inc** Provider No. **004-7191** Report Period Beginning: **10/13/2006** Ending: **4/30/2007**

RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
Name	City	Name	City	Type of Business
Heather Health Care Center, Inc.	Harvey	The Forum Professional Center, LP	Chicago	Home Office rental
Alden-Long Grove Rehabilitation and Health Care Center, Inc.	Long Grove	Forum Extended Care Services II, Inc.	Chicago	Pharmacy
Alden-Lincoln Park Rehabilitation and Health Care Center, Inc.	Chicago	Alden Management Services, Inc.	Chicago	Management
Alden-Northmoor Rehabilitation and Health Care Center, Inc.	Chicago			
Alden-Lakeland Rehabilitation and Health Care Center, Inc.	Chicago			
Alden of Old Town East, Inc.	Bloomingtondale	Alden Garden Courts of DesPlaines, LLC	DesPlaines	Assisted Living/Alzheimers Facility
Morrow Health Care Center, Inc.	Chicago	Alden Courts of Waterford, LLC	Aurora	Alzheimers Facility
Alden - Wentworth Rehabilitation and Health Care Center, Inc.	Chicago	Alden Gardens of Waterford, LLC	Aurora	Assisted Living
Alden - Naperville Rehabilitation and Health Care Center, Inc.	Naperville	Prism Health Care Services, Inc.	Schaumburg	Nursing and Durable Equipment
Alden - Valley Ridge Rehabilitation and Health Care Center, Inc.	Bloomingtondale	Community Physical Therapy & Associates, Ltd.	Wood Dale	Therapy Provider
Alden Village Health Facility for Children and Young Adults, Inc.	Bloomingtondale	Alden Bennett Construction Company, Inc.	Chicago	General Contractor
Alden - Orland Park Rehabilitation and Health Care Center, Inc.	Orland Park			
Alden - Princeton Rehabilitation and Health Care Center, Inc.	Chicago			
Alden of Old Town West, Inc.	Bloomingtondale			
Alden - Town Manor Rehabilitation and Health Care Center, Inc.	Cicero			
Alden Trails, Inc.	Bloomingtondale			
Alden - Poplar Creek Rehabilitation and Health Care Center, Inc.	Hoffman Estates			
Alden - North Shore Rehabilitation and Health Care Center, Inc.	Skokie			
Alden - Des Plaines Rehabilitation and Health Care Center, Inc.	Des Plaines			
Alden Estates of Evanston, Inc.	Evanston			
Alden - Alma Nelson Manor, Inc.	Rockford			
Alden - Park Strathmoor, Inc.	Rockford			
Alden - Meadow Park Health Care Center, Inc.	Clinton, WI			
Alden Estates of Barrington, Inc.	Barrington			
Alden of Waterford, LLC	Aurora			

Facility Name &amp; ID Number

ALDEN SPRINGS

#

0047191

Report Period Beginning:

10/13/06

Ending:

4/30/07

## 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/CFO	CEO	100.00	139,471	0.8	0.02	Salary	\$ 29	27-7	1
2	Lauren Magnusson	Clinical Coordinator	Nursing	0.00	81,748	0.8	0.02	Salary	17	15-7	2
3	Terry Magnusson	Maint. Superv.	Maint.	0.00	53,034	0.8	0.02	Salary	11	7-7	3
4											4
5											5
6	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 57		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 SPRINGS

# 0047191

Report Period Beginning:

10/13/06

Ending:

4/30/07

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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	19	Professional Fees	Patient Days	2,609,726	30	\$ 1,178,723	\$ 548	\$ 248	1	
2	21	Gen'l & Administrative	Patient Days	2,609,726	30	1,530,965	548	322	2	
3	5	Utilities	Patient Days	2,609,726	30	138,129	548	29	3	
4	6	Repairs & Maintenance	Patient Days	2,609,726	30	382,333	548	80	4	
5	24	Travel & Seminar	Patient Days	2,609,726	30	88,963	548	19	5	
6	25	Other Admin. Travel	Patient Days	2,609,726	30	483,114	548	102	6	
7	26	Insurance	Patient Days	2,609,726	30	11,296	548	2	7	
8	20	Dues & Subscriptions	Patient Days	2,609,726	30	103,549	548	22	8	
9	30	Depreciation	Months Active	341	30	149,985	6	2,566	9	
10	31	Amortization	Patient Days	2,609,726	30	132,881	548	28	10	
11	33	Real Estate Tax	Patient Days	2,609,726	30	307,347	548	65	11	
12	35	Rent-Equip & Vehicles	Patient Days	2,609,726	30	1,738,301	548	365	12	
13	32	Interest	Patient Days	2,609,726	30	4,447,634	548	934	13	
14	7	Gen'l Serv Salaries	Patient Days	2,609,726	30	1,969,002	1,969,002	548	414	14
15	15	Health Care Salaries	Patient Days	2,609,726	30	1,722,000	1,722,000	548	362	15
16	27	Gen'l & Admin Salaries	Patient Days	2,609,726	30	19,312,029	19,312,029	548	4,058	16
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 33,696,251	\$ 23,003,031	\$ 9,616	25	

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Harris		X	Mortgage	\$10,752.46	12/1/06	\$ 1,781,000	\$ 1,766,341	11/1/2011	5.2500	\$ 60,808	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Related Party FECII										5	6								
7	Related Party AMS										933	7								
8	Related Party CPT										7	8								
9	<b>TOTAL Facility Related</b>				\$10,752.46		\$ 1,781,000	\$ 1,766,341			\$ 61,753	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,781,000	\$ 1,766,341			\$ 61,753	15								

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.)



**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 SPRINGS COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0047191

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>02-23-300-024</u>	<u>Nursing Home Facility</u>	\$ <u>3,631.64</u>	\$ <u>3,631.64</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>3,631.64</u>	\$ <u>3,631.64</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 SPRINGS

# 0047191 Report Period Beginning:

10/13/06 Ending:

4/30/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 7,150 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories One

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>22,035</u>		<u>\$ 398,630</u>	1
2					2
3	<b>TOTALS</b>	<b>22,035</b>		<b>\$ 398,630</b>	<b>3</b>

Facility Name & ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning:

10/13/06

Ending:

4/30/07

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			2006	\$ 1,583,599	\$ 23,144	40	\$ 23,144		\$ 24,108	4
5				2006	69,510	964	40	964		964	5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10											10
11		Plumb, Floor Prep, Fencing-ABC Renovation		2007	23,127	96	40	96		96	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning:

10/13/06

Ending:

4/30/07

**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	Related Party-Forum Prof Center Building:		\$	\$		\$	\$	\$	37
38	Leasehold Improvement-Remodeling	1980	11,260		15			11,260	38
39	Leasehold Improvement-Remodeling	1980	17,639		20			17,639	39
40	Leasehold Improvement-Tenant Improvement	1987	912		13			912	40
41	Leasehold Improvement-AMS Remodel	1988	14,634		10			14,634	41
42	Leasehold Improvement-Roof	1994	3,269	111	16	111		2,453	42
43	Leasehold Improvement-Build.Improv.	1996	1,153	39	16	39		789	43
44	Leasehold Improvement-Asphalting	2000	89		3			89	44
45	Leasehold Improvement-DAI	2001	157	9	10	9		81	45
46	Leasehold Improvement-Bathrooms	2002	681	42	7	42		324	46
47	Leasehold Improvement-Suite Renovation	2003	1,672	90	10	90		669	47
48	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	2,071	195	7	195		835	48
49	Leasehold Improvement-Add-on Improvement, fixture base	1980	73		23			73	49
50	Leasehold Improvement-Add-on Improvement, lighting base	2001	126	3	5	3		126	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60	Related Party-AMS:								60
61	Leasehold Improvement-Remodeling	1993	6,060		7			6,060	61
62	Leasehold Improvement-Remodeling	2002	4,961	384	7	384		2,746	62
63	Leasehold Improvement-Remodeling	2003	5,189	401	7	401		2,856	63
64									64
65									65
66									66
67	Forum Extended Care, LLC-building/building improv	1999	12,434	159	30	159		2,350	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,758,616	\$ 25,637		\$ 25,637	\$	\$ 89,064	70

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

Facility Name & ID Number ALDEN SPRINGS # 0047191 Report Period Beginning: 10/13/06 Ending: 4/30/07

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	\$ 189,332	\$ 13,923	\$ 13,923	\$	Various	\$ 7,933	71
72	Current Year Purchases	852	14	14		Various	14	72
73	Fully Depreciated Assets					Various		73
74								74
75	TOTALS	\$ 190,184	\$ 13,937	\$ 13,937	\$		\$ 7,947	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$	2,347,430	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	39,574	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	39,574	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)	\$	97,011	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning: 10/13/06

Ending: 4/30/07

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: related party, costs 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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning 1/1/07

Ending 11/1/2011

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

Fiscal Year Ending                      Annual Rent

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 96      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>Rent Equip &amp; Vehic</u>	<u>Related Party</u>	\$ <u>56.31</u>	\$ <u>366</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>56.31</u>	\$ <u>366</u>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled 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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							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			0				9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>Related Party CPT</b>	See Pg 16A				67			67	13
14	<b>TOTAL</b>			\$		\$ 67	\$		\$ 67	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	\$ 239
2. ST	39-3	To Col 5	944
3.			
4. PT	39-3	To Col 5	1,480
5.			
6.			
7.			
8.			
Less: DD facility, cost is moved to Line 10A			(2,664)
Pharmacy Supplies per GL			0
Manual Input from Related Party- Forum Drugs			0
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	0
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0
Total Exceptional Care (Line 12, Col 8)			0
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	
Other			1,208
Manual Input: Related Party - Prism			(1,147)
Manual Input: Related Party FECII - I.V.			5
Oxygen, from reclass worksheet			
13. Col 6: Supplies Total		To Col 6	67
13. Total Line 13, Column 8			67
14. Total			\$ 67

Facility Name & ID Number ALDEN SPRINGS# 0047191Report Period Beginning: 10/13/06

Ending:

4/30/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 4/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 60,597	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	214,443	214,443	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		1,326	6
7	Other Prepaid Expenses	483	10,665	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from S/holders</u>		17,589	9
	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 214,926	\$ 304,620	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		398,630	13
14	Buildings, at Historical Cost		1,653,109	14
15	Leasehold Improvements, at Historical Cost	18,677	41,804	15
16	Equipment, at Historical Cost	6,130	189,148	16
17	Accumulated Depreciation (book methods)	(1,766)	(36,104)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Investments</u>			23
	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 23,041	\$ 2,246,588	24
	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 237,967	\$ 2,551,208	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 53,719	\$ 334,526	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		43,080	29
30	Accrued Salaries Payable	20,505	20,505	30
	Accrued Taxes Payable (excluding real estate taxes)	5,924	5,924	31
32	Accrued Real Estate Taxes(Sch.IX-B)		4,837	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>accr ins, exps, idpa, sales tax, etc</u>	14,555	14,555	36
37	<u>D/T Rel. Parties</u>	359,341	187,218	37
	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 454,044	\$ 610,646	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		1,723,261	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 1,723,261	45
	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 454,044	\$ 2,333,907	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (216,077)	\$ 217,301	47
	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 237,967	\$ 2,551,208	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(216,077)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (216,077)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (216,077)	<b>24</b> *

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

Facility Name &amp; ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning: 10/13/06

Ending: 4/30/07

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 185,518	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 185,518	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 185,518	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	55,339	31
32	Health Care	150,055	32
33	General Administration	65,400	33
<b>B. Capital Expense</b>			
34	Ownership	85,059	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,878	35
36	Provider Participation Fee	41,864	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 401,595	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(216,077)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (216,077)	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 SPRINGS

# 0047191

Report Period Beginning: 10/13/06

Ending:

4/30/07

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing				1
2	Assistant Director of Nursing				2
3	Registered Nurses	6	161	26.83	3
4	Licensed Practical Nurses	1,673	46,559	27.83	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	640	9,402	14.69	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator	341	5,938	16.18	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	984	14,889	15.13	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	5,981	74,714	12.35	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	9,625	151,663 *	15.60	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	Monthly 750		36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 224		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	93 5,015		44
45	Social Service Consultant	6 384		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	99 \$ 6,373		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number ALDEN SPRINGS

# 0047191

Report Period Beginning: 10/13/06

Ending: 4/30/07

**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	
Melissa Allison	Administrator	0	\$ 4,691	Workers' Compensation Insurance	\$ 4,416	IDPH License Fee	\$	
Latricia Davis	Administrator	0	1,247	Unemployment Compensation Insurance	288	Advertising: Employee Recruitment	649	
				FICA Taxes	15,010	Health Care Worker Background Check		
				Employee Health Insurance	749	(Indicate # of checks performed <u>9</u> )	90	
				Employee Meals	381	Patient Background Checks <u>4</u>	40	
				Illinois Municipal Retirement Fund (IMRF)*		Related Party-AMS	21	
				Dental, Life Costs	(6)	Jewish News	11	
				Employee Vaccinations	110			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 5,938			Non-allowable advertising	( )	
B. Administrative - Other						Yellow page advertising	( )	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$				\$ 812	
TOTAL (agree to Schedule V, line 17, col. 3)			\$			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)						Description		
C. Professional Services						Amount		
Vendor/Payee	Type		Amount	Description	Line #			
AMS	Management Fees		\$ 12,986				Out-of-State Travel	
Medicom	Billing Servicing		7				\$	
Ken Fisch	Legal Fees		374					
Ungaretti Harris/Marsh USA	Legal Fees		226				In-State Travel	
							Related Party AMS	
							19	
							Seminar Expense	
							Deming Training Fee	
							319	
							Experience, Inc.	
							310	
							American Express-Seminar	
							162	
							Entertainment Expense	
							( )	
TOTAL (agree to Schedule V, line 19, column 3)							TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 13,593					\$ 810

\* Attach copy of IMRF notifications

\*\*See instructions.



**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? No  
If YES, give association name and amount. \_\_\_\_\_
- (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. \$ 727 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. \$ 41,864  
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. \$ 357 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 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? Yes  
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? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.