

		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: 0042051

Facility Name: Alden Trails

Address: 273 East Army Trail Road Bloomington 60108
 Number City Zip Code

County: Dupage

Telephone Number: (630)671-1990 **Fax #** (630)671-0540

HFS ID Number: 36-3966582

Date of Initial License for Current Owners: 05/19/98

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven M. Kroll</u>	
	(Title) <u>Chief Financial Officer</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number Alden Trails# 0042051 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	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	<u>5,363</u>			<u>5,363</u>
14	TOTALS	<u>5,363</u>			<u>5,363</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.83%

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

434 (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)

NoneF. 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 08/15/98

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

YES Date 08/15/98 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

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	46,281	3,675		49,956	516	50,472		50,472		1
2	Food Purchase		29,482		29,482	(5,335)	24,147	(112)	24,035		2
3	Housekeeping	14,246	5,033	82	19,361		19,361		19,361		3
4	Laundry		1,234		1,234		1,234		1,234		4
5	Heat and Other Utilities			18,238	18,238		18,238	(22)	18,216		5
6	Maintenance			32,869	32,869		32,869	1,021	33,890		6
7	Other (specify):* Related Party Salary							4,046	4,046		7
8	TOTAL General Services	60,527	39,424	51,189	151,140	(4,819)	146,321	4,933	151,254		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	349,786	10,520	834	361,140	420	361,560	(99)	361,461		10
10a	Therapy					3,938	3,938	(2,869)	1,069		10a
11	Activities			22,991	22,991		22,991		22,991		11
12	Social Services	46,909			46,909		46,909		46,909		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Salary							3,539	3,539		15
16	TOTAL Health Care and Programs	396,695	10,520	27,825	435,040	4,358	439,398	571	439,969		16
	C. General Administration										
17	Administrative	11,723			11,723		11,723		11,723		17
18	Directors Fees										18
19	Professional Services			87,316	87,316		87,316	(77,914)	9,402		19
20	Dues, Fees, Subscriptions & Promotions			3,779	3,779		3,779	(1,764)	2,015		20
21	Clerical & General Office Expenses		2,136	13,111	15,247		15,247	2,684	17,931		21
22	Employee Benefits & Payroll Taxes			70,141	70,141	4,399	74,540		74,540		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,666	1,666		1,666	183	1,849		24
25	Other Admin. Staff Transportation							993	993		25
26	Insurance-Prop.Liab.Malpractice			16,896	16,896		16,896	1,406	18,302		26
27	Other (specify):* Related Party Salary			1,945	1,945		1,945	37,947	39,892		27
28	TOTAL General Administration	11,723	2,136	194,854	208,713	4,399	213,112	(36,465)	176,647		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	468,945	52,080	273,868	794,893	3,938	798,831	(30,961)	767,870		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 Trails #0042051 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			8,090	8,090		8,090	36,357	44,447			30
31	Amortization of Pre-Op. & Org.							875	875			31
32	Interest			24,041	24,041		24,041	54,551	78,592			32
33	Real Estate Taxes							15,834	15,834			33
34	Rent-Facility & Grounds			93,742	93,742		93,742	(93,742)				34
35	Rent-Equipment & Vehicles			4,335	4,335		4,335	3,572	7,907			35
36	Other (specify):* MIP & Amortiz.							6,904	6,904			36
37	TOTAL Ownership			130,208	130,208		130,208	24,351	154,559			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,139	3,938	7,077	(3,938)	3,139	(1,958)	1,181			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,003	70,003		70,003		70,003			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		3,139	73,941	77,080	(3,938)	73,142	(1,958)	71,184			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	468,945	55,219	478,017	1,002,181		1,002,181	(8,568)	993,613			45

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

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
22		(936.00)	Uniforms
	1	516.00	Uniforms
	10	420.00	Uniforms
2		(5,335.00)	Employee Meal
	22	5,335.00	Employee Meal
39		(3,816.00)	PT, ST, OT, CPT - DD facilities
10A		3,816.00	PT, ST, OT, CPT - DD facilities

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Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/06

Ending:

12/31/06

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(409)	21		17
18	Fines and Penalties	(608)	32		18
19	Entertainment	(123)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(175)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,944)	27		24
25	Fund Raising, Advertising and Promotional	(1,488)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(366)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,113)		\$	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)	3,229	Various	34
35	Other- Attach Schedule See Pg 5A	(6,684)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,455)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (8,568)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Alden Trails

ID# 0042051
 Report Period Beginning: 01/01/06
 Ending: 12/31/06

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	Late fees on utilities	(306)	5	2
3	Late fee on telephone	(15)	21	3
4	ADJ Real Est Tax to Actual	1,126	33	4
5				5
6				6
7				7
8	Intercompany interest is not allowed	(7,377)	32	8
9				9
10	Miscell Income	(112)	2	10
11				11
12				12
13				13
14				14
15	Vendor Settlements Comed	(342)	21	15
16	Vendor Settlements Comed	342	6	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	Total	(6,684)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(112)	0	0	0	0	0	0	0	0	0	0	(112)	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	(306)	0	284	0	0	0	0	0	0	0	0	(22)	5
6	Maintenance	342	0	786	0	0	0	(107)	0	0	0	0	1,021	6
7	Other (specify):*	0	0	4,046	0	0	0	0	0	0	0	0	4,046	7
8	TOTAL General Services	(76)	0	5,116	0	0	0	(107)	0	0	0	0	4,933	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	0	0	0	0	(99)	0	0	0	0	0	0	(99)	10
10a	Therapy	0	0	0	0	0	(2,869)	0	0	0	0	0	(2,869)	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	3,539	0	0	0	0	0	0	0	0	3,539	15
16	TOTAL Health Care and Programs	0	0	3,539	0	(99)	(2,869)	0	0	0	0	0	571	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	(175)	1,509	(79,248)	0	0	0	0	0	0	0	0	(77,914)	19
20	Fees, Subscriptions & Promotions	(1,977)	0	213	0	0	0	0	0	0	0	0	(1,764)	20
21	Clerical & General Office Expenses	(766)	117	3,146	124	63	0	0	0	0	0	0	2,684	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	183	0	0	0	0	0	0	0	0	183	24
25	Other Admin. Staff Transportation	0	0	993	0	0	0	0	0	0	0	0	993	25
26	Insurance-Prop.Liab.Malpractice	0	1,383	23	0	0	0	0	0	0	0	0	1,406	26
27	Other (specify):*	(1,944)	0	39,686	161	44	0	0	0	0	0	0	37,947	27
28	TOTAL General Administration	(4,862)	3,009	(35,004)	285	107	0	0	0	0	0	0	(36,465)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,938)	3,009	(26,349)	285	8	(2,869)	(107)	0	0	0	0	(30,961)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	29,221	5,278	0	1,858	0	0	0	0	0	0	36,357	30
31	Amortization of Pre-Op. & Org.	0	602	273	0	0	0	0	0	0	0	0	875	31
32	Interest	(7,985)	53,377	9,140	0	9	10	0	0	0	0	0	54,551	32
33	Real Estate Taxes	1,126	14,073	632	0	3	0	0	0	0	0	0	15,834	33
34	Rent-Facility & Grounds	0	(93,742)	0	0	0	0	0	0	0	0	0	(93,742)	34
35	Rent-Equipment & Vehicles	0	0	3,572	0	0	0	0	0	0	0	0	3,572	35
36	Other (specify):*	0	6,904	0	0	0	0	0	0	0	0	0	6,904	36
37	TOTAL Ownership	(6,859)	10,435	18,895	0	1,870	10	0	0	0	0	0	24,351	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	(1,958)	0	0	0	0	0	0	0	(1,958)	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	(1,958)	0	0	0	0	0	0	0	(1,958)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(11,797)	13,444	(7,454)	(1,673)	1,878	(2,859)	(107)	0	0	0	0	(8,568)	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
The Alden Group, Ltd.	100	See Pg 6K		See Pg 6K		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	\$ 93,742	Alden of Bloomingdale Limited Partnership		\$	\$ (93,742)	1
2	V	32 Interest Income	16,058	Alden of Bloomingdale Limited Partnership			(16,058)	2
3	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		1,500	1,500	3
4	V	19 Legal Fees: Non-Collections		Alden of Bloomingdale Limited Partnership		9	9	4
5	V	21 Dues & Subscriptions		Alden of Bloomingdale Limited Partnership		117	117	5
6	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		14,073	14,073	6
7	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,383	1,383	7
8	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		6,904	6,904	8
9	V	32 Interest - Other		Alden of Bloomingdale Limited Partnership		47,056	47,056	9
10	V	32 Interest - IOD		Alden of Bloomingdale Limited Partnership		22,379	22,379	10
11	V	30 Depreciation Exp		Alden of Bloomingdale Limited Partnership		29,221	29,221	11
12	V	31 Amortization Exp		Alden of Bloomingdale Limited Partnership		602	602	12
13	V							13
14	Total		\$ 109,800			\$ 123,244	\$ * 13,444	14

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

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/06

Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Fees	\$ 81,670	Alden Management Services, Inc.		\$ 2,422	\$ (79,248)	15
16	V	21 Gen'l & Admin				3,146	3,146	16
17	V	5 Utilities				284	284	17
18	V	6 Rep & Maint				786	786	18
19	V	24 Travel & Seminar				183	183	19
20	V	25 Other Admin Travel				993	993	20
21	V	26 Forum Allocated Insurance				23	23	21
22	V	20 Dues, Subscriptions				213	213	22
23	V	30 Depreciation				5,278	5,278	23
24	V	31 Amortization				273	273	24
25	V	33 Real estate taxes				632	632	25
26	V	35 Rent-Equip. & Vehic				3,572	3,572	26
27	V	32 Interest				9,140	9,140	27
28	V	7 Gen'l Serv Salary				4,046	4,046	28
29	V	15 Health Care Salary				3,539	3,539	29
30	V	27 G & A Salaries				39,686	39,686	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		\$ 81,670			\$ 74,216	\$ * (7,454)	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	\$ 2,427	Prism Health Care Services, Inc.		\$ 469	\$ (1,958)	15
16	V	27	G&A: Salary				161	161	16
17	V	21	G&A				124	124	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			\$ 2,427			\$ 754	\$ * (1,673)	39

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

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/06

Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$	Forum Extended Care Services II, Inc.		\$		15
16	V	39 Drugs	249			350	101	16
17	V	39 Wound Care	463			362	(101)	17
18	V	10 House Stock	548			494	(54)	18
19	V	10 Pharm Consult	384			339	(45)	19
20	V	27 Employ Vaccin	124			97	(27)	20
21	V	27 G & A Salary				71	71	21
22	V	21 Gen'l & Admin				63	63	22
23	V	32 Interest				9	9	23
24	V	33 Real Estate Tax				3	3	24
25	V	30 Depreciation				1,858	1,858	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,768			\$ 3,646	\$ * 1,878	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	\$ 3,816	Community Physical Therapy & Associates, Ltd.		\$ 947	\$ (2,869)	15
16	V	32	Interest				10	10	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			\$ 3,816			\$ 957	\$ * (2,859)	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	\$ 6,986	Alden Bennett Construction Company, Inc.		\$ 6,879	\$ (107)	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			\$ 6,986			\$ 6,879	\$ *	(107) 39

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

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NURSING CENTER - ALDEN OF TRAILS # 42051

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 Waterford	Aurora
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Northmoor	Chicago
ANC Princeton	Chicago
Alden Orland Park	Orland Park
Alden of Old Town West	Bloomingtondale
Alden of Old Town East	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Clinton, WI
ANC Poplar Creek	Hoffman Estates
ANC Estates of Barrington	Barrington
ANC Gardens of Rockford	Rockford
ANC Springs	Bloomingtondale

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

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg a.	President	President	100.00	138,831	0.192	0.48	Salary	\$ 669	27-7	1
2	Lauren Magnusson b.	Coordinator	Nursing		81,373	0.192	0.48	Salary	392	15-7	2
3	Terry Magnusson c.	Maintenance Supr	Maint.		52,791	0.192	0.48	Salary	254	7-7	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of The Alden Group, Inc.										6
7	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinaor.										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	\$ 1,315		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 Trails

0042051

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W Peterson Ave
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 286-3883
 Fax Number (773) 286-3743

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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	Operating Loss Loan	\$2,122.33	6/02	\$ 339,267	\$ 326,953	09/2037	6.8600	\$ 22,379	1								
2	Cambridge		X	Mortgage	\$4,506.29	9/03	873,700	851,724	08/2043	5.5000	47,054	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Related Party-FECHII	X		Working Capital							9	6								
7	Related Party-AMS	X		Working Capital							9,140	7								
8	Related Party - CPT	X		Working Capital							10	8								
9	TOTAL Facility Related				\$6,628.62		\$ 1,212,967	\$ 1,178,677			\$ 78,592	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,178,677			\$ 78,592	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,904 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.)

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 Trails COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0042051

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>02-23-301-016</u>	<u>Nursing Home Facility</u>	\$ <u>14,678.00</u>	\$ <u>14,678.00</u>
2. <u>See Attached</u>	<u>Related Party - AMS</u>	\$ <u>131,720.00</u>	\$ <u>632.00</u>
3. <u>See Attached</u>	<u>Related Party - Forum</u>	\$ <u>14,554.00</u>	\$ <u>3.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>160,952.00</u>	\$ <u>15,313.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Alden Trails

0042051 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,610 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>38,474</u>	<u>1995</u>	<u>\$ 147,679</u>	1
2					2
3	TOTALS	38,474		\$ 147,679	3

Facility Name & ID Number Alden Trails

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	Related party-Forum			1978	\$ 14,839	\$	25	\$		\$ 14,839	4
5	16		1997	1997	934,861	23,372	40	23,372		199,279	5
6											6
7											7
8											8
	Improvement Type**										
9	2 TV Modules			1999	1,775		5			1,775	9
10	Sprinkler System			1999	1,690	113	15	113		883	10
11	Replace heads-Irrigation system			1998	1,653	110	15	110		946	11
12											12
13	Carpentry, Ceramic,Quarry, Corain tops			2003	14,274	1,427	10	1,427		5,709	13
14											14
15	Panels			2003	5,175	1,035	5	1,035		4,140	15
16											16
17	X-pefit: ceiling light covers			2004	1,380	276	5	276		552	17
18	Aqua Plumbing: repair discharge line for lift station pump			2004	1,683	112	15	112		299	18
19	Alden Bennett: lift station pumps and controls			2004	4,298	287	15	287		741	19
20											20
21	Replaced Floor Tile			2006	2,730	227	10	227		227	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 984,359	\$ 26,959		\$ 26,959	\$	\$ 229,390	1
2									2
3	Related Party-Forum Prof Center Building:								3
4	Leasehold Improvement-Remodeling	1980	11,260		15			11,260	4
5	Leasehold Improvement-Remodeling	1980	17,639		20			17,639	5
6	Leasehold Improvement-Tenant Improvement	1987	912		13			912	6
7	Leasehold Improvement-AMS Remodel	1988	14,634		10			14,634	7
8	Leasehold Improvement-Roof	1994	3,269	204	16	204		2,453	8
9	Leasehold Improvement-Build.Improv.	1996	1,153	72	16	72		789	9
10	Leasehold Improvement-Asphalting	2000	89		3			89	10
11	Leasehold Improvement-DAI	2001	157	16	10	16		81	11
12	Leasehold Improvement-Bathrooms	2002	681	77	7	77		324	12
13	Leasehold Improvement-Suite Renovation	2003	1,672	167	10	167		669	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	2,071	360	7	360		835	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	73		23			73	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	126	6	5	6		126	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,060		7			6,060	27
28	Leasehold Improvement-Remodeling	2002	4,961	709	7	709		2,746	28
29	Leasehold Improvement-Remodeling	2003	5,189	741	7	741		2,856	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	12,434	293	30	293		2,350	33
34	TOTAL (lines 1 thru 33)		\$ 1,066,739	\$ 29,604		\$ 29,604	\$	\$ 293,286	34

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

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 139,518	\$ 13,503	\$ 13,503	\$	Various	\$ 83,539	71
72	Current Year Purchases	2,086	168	168		Various	168	72
73	Fully Depreciated Assets	68,355	1,059	1,059		Various	68,355	73
74								74
75	TOTALS	\$ 209,959	\$ 14,730	\$ 14,730	\$		\$ 152,062	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	AMS-Bus/Travel Van	Chev/Lumina/00/Various	98-04	\$ 4,634	\$ 113	\$ 113	\$	3	\$ 4,747	76
77	Busses Transfer from AMS to Trails			16,646					16,646	77
78										78
79										79
80	TOTALS			\$ 21,280	\$ 113	\$ 113	\$		\$ 21,393	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)	\$ 1,445,657	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,447	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,447	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)	\$ 466,741	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

10. Effective dates of current rental agreement:

Beginning 12/2/96

Ending 11/30/2036

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: \$ 4,335 Description: Copy Machine Lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related Party AMS</u>		\$ <u>297.67</u>	\$ <u>3,572</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>297.67</u>	\$ <u>3,572</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)	
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	\$		\$	\$		\$	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				350		350	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					831		831	13
14	TOTAL			\$		\$	\$ 1,181		\$ 1,181	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	\$112.08
2. ST	39-3	To Col 5	447.81
3.			
4. PT	39-3	To Col 5	3,378.18
5.			
6.			
7.			
8.			
Less: PT, OT, & ST costs reclassified to Ln 10A for "DD" type facilities			(3,938.07)
Pharmacy Supplies per GL			248.98
Manual Input from Related Party- Forum Drugs			101.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	349.98
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		To Col 5	
Other			2,889.85
Manual Input: Related Party - Prism			(1,958.00)
Manual Input: Related Party FECII - I.V.			(101.00)
13. Col 6: Supplies Total		To Col 6	830.85
13. Total Line 13, Column 8			830.85
14. Total			1,180.83

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>600</u>)	397,916	397,916	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,330	1,330	7
8	Accounts Receivable (owners or related parties)	(216,131)		8
9	Other(specify): <u>Due from 3rd parties</u>	29,515	50,266	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 212,630	\$ 449,512	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		147,679	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	41,217	45,975	15
16	Equipment, at Historical Cost	65,024	146,159	16
17	Accumulated Depreciation (book methods)	(67,491)	(311,335)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		45,252	21
22	Other Long-Term Assets (specify):	613,749	615,650	22
23	Other(specify): <u>Refin Fee, Accum Amortiz Refin Fee</u>		19,927	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 652,499	\$ 1,644,168	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 865,129	\$ 2,093,680	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 74,473	\$ 62,981	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,127	7,127	28
29	Short-Term Notes Payable		10,652	29
30	Accrued Salaries Payable	28,596	28,596	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,128	3,128	31
32	Accrued Real Estate Taxes(Sch.IX-B)		15,271	32
33	Accrued Interest Payable	1,230	1,230	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr Ins, Accr Exp, IDPA</u>	18,307	23,975	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 132,861	\$ 152,960	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		323,716	39
40	Mortgage Payable		844,308	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Affiliates</u>	12,732	12,732	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,732	\$ 1,180,756	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 145,593	\$ 1,333,716	46
47	TOTAL EQUITY(page 18, line 24)	\$ 719,536	\$ 759,964	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 865,129	\$ 2,093,680	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 537,121	1
2	Restatements (describe):		2
3	external audit adjustments made after 2005 cost report		3
4	was submitted. These have no effect on prior years report.	17,187	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 554,308	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	165,228	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) Retained Earnings&Capital Shareholders		15
16	Other (describe) Net (Income)/Loss		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 165,228	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)	\$ 719,536	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Trails

0042051

Report Period Beginning: 01/01/06

Ending: 12/31/06

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,166,711	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,166,711	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Adjs to Prior Yr costs & Misc Income	698	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 698	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,167,409	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	151,140	31
32	Health Care	435,040	32
33	General Administration	208,713	33
B. Capital Expense			
34	Ownership	130,208	34
C. Ancillary Expense			
35	Special Cost Centers	7,077	35
36	Provider Participation Fee	70,003	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,002,181	40
41	Income before Income Taxes (line 30 minus line 40)**	165,228	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 165,228	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 Trails

0042051

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing				1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	3,434	3,547	97,346	27.44	3
4	Licensed Practical Nurses	813	1,074	23,713	22.08	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	3,888	3,976	46,133	11.60	14
15	Cook Helpers/Assistants	15	15	148	9.87	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,376	1,612	14,246	8.84	18
19	Laundry					19
20	Administrator	450	450	11,723	26.05	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)	2,604	2,732	46,909	17.17	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	19,891	21,066	228,727	10.86	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	32,471	34,472	\$ 468,945 *	\$ 13.60	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	4,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	384	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	408	22,021	11-3	44
45	Social Service Consultant	18	971	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	426	\$ 27,376		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 Trails

0042051

Report Period Beginning: 01/01/06

Ending: 12/31/06

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		\$ 9,353	Workers' Compensation Insurance	\$ 11,017	IDPH License Fee	\$	
Latricia Davis	Administrator		2,370	Unemployment Compensation Insurance	20,507	Advertising: Employee Recruitment		
				FICA Taxes	30,829	Health Care Worker Background Check	100	
				Employee Health Insurance	6,319	(Indicate # of checks performed 10)		
				Employee Meals	5,335	Patient Background Checks	16	
				Illinois Municipal Retirement Fund (IMRF)*		Related Party AMS	213	
				Dental Ins, Life Ins, Misc Payroll Costs	195	Surety Bond, Illinois Health Care Assoc	1,542	
				Employee Drug Tests, 401K Match	214			
				Employee Vaccinations	124			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 11,723	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,015		
(List each licensed administrator separately.)								
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	
							Related Party AMS	183
							Gas Exp	1,059
							Seminar Expense	
							Seminars/Conventions	528
							Leadership Training	79
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
AMS	Management Fees		\$ 81,670					
BDO Seidman/Reznick	Accounting Fees		3,101					
Barry Greenberg	Legal Fees: Non-Collections		2,450					
Condon 401K/Marsh USA	401k admin/other		95					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 87,316					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Trails

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Il. Health Care Assn. \$1242
- (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. \$ 2,829 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. \$ 70,003
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. \$ 5,335 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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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? No
Attach invoices and a summary of services for all architect and appraisal fees.