

		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:** 0042069

**Facility Name:** Alden of Old Town East

**Address:** 108 South First Street Bloomington 60108  
 Number City Zip Code

**County:** Dupage

**Telephone Number:** (630)671-1703 **Fax #** (630)671-1706

**HFS ID Number:** 36-3966584

**Date of Initial License for Current Owners:** 05/09/98

**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
<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 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven M Kroll</u>	
	(Title) <u>Chief Financial Officer</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

**Phone # (217) 782-1630**

Facility Name & ID Number Alden of Old Town East# 0042069 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>5,112</u>	<u>342</u>		<u>5,454</u>
14	TOTALS	<u>5,112</u>	<u>342</u>		<u>5,454</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.39%

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

348 (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 &amp; 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 07/06/98

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

YES  Date 07/06/98 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

ACCURAL  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 of Old Town East # 0042069 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	
	<b>A. General Services</b>											
1	Dietary	48,369	4,522		52,891	22	52,913		52,913			1
2	Food Purchase		32,736		32,736	(3,015)	29,721	5,260	34,981			2
3	Housekeeping	14,246	6,572		20,818	377	21,195		21,195			3
4	Laundry		2,153		2,153		2,153	(110)	2,043			4
5	Heat and Other Utilities			16,444	16,444		16,444	111	16,555			5
6	Maintenance			26,432	26,432		26,432	1,866	28,298			6
7	Other (specify):* <b>Related Party Salary</b>							4,113	4,113			7
8	<b>TOTAL General Services</b>	62,615	45,983	42,876	151,474	(2,616)	148,858	11,240	160,098			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	372,729	19,939	584	393,252	355	393,607		393,607			10
10a	Therapy					2,707	2,707	(1,855)	852			10a
11	Activities		2,046	23,052	25,098		25,098		25,098			11
12	Social Services	47,201			47,201		47,201		47,201			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <b>Related Party Salary</b>							3,597	3,597			15
16	<b>TOTAL Health Care and Programs</b>	419,930	21,985	27,636	469,551	3,062	472,613	1,742	474,355			16
	<b>C. General Administration</b>											
17	Administrative	11,723			11,723		11,723		11,723			17
18	Directors Fees											18
19	Professional Services			87,497	87,497		87,497	(77,704)	9,793			19
20	Dues, Fees, Subscriptions & Promotions			6,879	6,879		6,879	(2,567)	4,312			20
21	Clerical & General Office Expenses		7,141	10,623	17,764		17,764	2,682	20,446			21
22	Employee Benefits & Payroll Taxes			54,140	54,140	2,261	56,401		56,401			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,883	1,883		1,883	186	2,069			24
25	Other Admin. Staff Transportation							1,010	1,010			25
26	Insurance-Prop.Liab.Malpractice			16,896	16,896		16,896	1,407	18,303			26
27	Other (specify):* <b>Related Party Salary</b>			(3,930)	(3,930)		(3,930)	44,477	40,547			27
28	<b>TOTAL General Administration</b>	11,723	7,141	173,988	192,852	2,261	195,113	(30,509)	164,604			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	494,268	75,109	244,500	813,877	2,707	816,584	(17,527)	799,057			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 of Old Town East #0042069 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	
	<b>D. Ownership</b>											
30	Depreciation			4,854	4,854		4,854	36,275	41,129			30
31	Amortization of Pre-Op. & Org.							880	880			31
32	Interest			23,992	23,992		23,992	54,755	78,747			32
33	Real Estate Taxes							13,734	13,734			33
34	Rent-Facility & Grounds			93,742	93,742		93,742	(93,742)				34
35	Rent-Equipment & Vehicles			4,487	4,487		4,487	3,633	8,120			35
36	Other (specify):* <b>MIP &amp; Amortiz.</b>							6,904	6,904			36
37	<b>TOTAL Ownership</b>			127,075	127,075		127,075	22,439	149,514			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,750	2,707	4,457	(2,707)	1,750	(499)	1,251			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,038	70,038		70,038		70,038			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,750	72,745	74,495	(2,707)	71,788	(499)	71,289			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	494,268	76,859	444,320	1,015,447		1,015,447	4,413	1,019,860			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		(754.00)	Uniforms
	1	22.00	Uniforms
	3	377.00	Uniforms
	10	355.00	Uniforms
2		(3,015.00)	Meal Reclass
	22	3,015.00	Meal Reclass
39		(2,707.00)	PT/OT/ST
10A		2,707.00	PT/OT/ST
		<hr/>	
		-	

Facility Name & ID Number Alden of Old Town East

# 0042069

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	(464)	21		17
18	Fines and Penalties	(558)	32		18
19	Entertainment				19
20	Contributions	(123)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	3,930	27		24
25	Fund Raising, Advertising and Promotional	(2,023)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(135)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(366)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 261		\$	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)	12,145	Various	34
35	Other- Attach Schedule See Pg 5A	(7,993)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 4,152		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 4,413		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 of Old Town East

ID# 0042069

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		
2	Late fees on utilities	(178)	5	2
3	Late fee on telephone	(9)	21	3
4	ADJ R/E Tax to Actual-East	(985)	33	4
5				5
6				6
7				7
8	Intercompany interest is not allowed	(7,377)	32	8
9				9
10	Miscell Income	(74)	2	10
11				11
12				12
13				13
14	Back out 30.65% of PAC fees	(271)	20	14
15	Vendor Settlements Comed	(160)	21	15
16	Vendor Settlements Comed	160	6	16
17	R+M<2,500 Capitalize on books	983	6	17
18	To adjust Depr. To detail	(82)	30	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>	(7,993)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(74)	0	0	5,334	0	0	0	0	0	0	0	5,260	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	(110)	0	0	0	0	0	0	(110)	4
5	Heat and Other Utilities	(178)	0	289	0	0	0	0	0	0	0	0	111	5
6	Maintenance	1,143	0	799	0	0	0	(76)	0	0	0	0	1,866	6
7	Other (specify):*	0	0	4,113	0	0	0	0	0	0	0	0	4,113	7
8	<b>TOTAL General Services</b>	<b>891</b>	<b>0</b>	<b>5,201</b>	<b>5,334</b>	<b>(110)</b>	<b>0</b>	<b>(76)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11,240</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	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	(1,855)	0	0	0	0	0	(1,855)	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	3,597	0	0	0	0	0	0	0	0	3,597	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>3,597</b>	<b>0</b>	<b>0</b>	<b>(1,855)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,742</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	0	1,509	(79,213)	0	0	0	0	0	0	0	0	(77,704)	19
20	Fees, Subscriptions & Promotions	(2,783)	0	216	0	0	0	0	0	0	0	0	(2,567)	20
21	Clerical & General Office Expenses	(768)	117	3,200	52	81	0	0	0	0	0	0	2,682	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	186	0	0	0	0	0	0	0	0	186	24
25	Other Admin. Staff Transportation	0	0	1,010	0	0	0	0	0	0	0	0	1,010	25
26	Insurance-Prop.Liab.Malpractice	0	1,383	24	0	0	0	0	0	0	0	0	1,407	26
27	Other (specify):*	3,930	0	40,500	67	(20)	0	0	0	0	0	0	44,477	27
28	<b>TOTAL General Administration</b>	<b>379</b>	<b>3,009</b>	<b>(34,077)</b>	<b>119</b>	<b>61</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(30,509)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>1,270</b>	<b>3,009</b>	<b>(25,279)</b>	<b>5,453</b>	<b>(49)</b>	<b>(1,855)</b>	<b>(76)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(17,527)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town East

# 0042069

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	(82)	29,221	5,278	0	1,858	0	0	0	0	0	0	36,275	30
31	Amortization of Pre-Op. & Org.	0	602	278	0	0	0	0	0	0	0	0	880	31
32	Interest	(7,935)	53,377	9,295	0	11	7	0	0	0	0	0	54,755	32
33	Real Estate Taxes	(985)	14,073	642	0	4	0	0	0	0	0	0	13,734	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	3,633	0	0	0	0	0	0	0	0	3,633	35
36	Other (specify):*	0	6,904	0	0	0	0	0	0	0	0	0	6,904	36
37	<b>TOTAL Ownership</b>	<b>(9,002)</b>	<b>10,435</b>	<b>19,126</b>	<b>0</b>	<b>1,873</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>22,439</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	(781)	282	0	0	0	0	0	0	(499)	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>(781)</b>	<b>282</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(499)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(7,732)</b>	<b>13,444</b>	<b>(6,153)</b>	<b>4,672</b>	<b>2,106</b>	<b>(1,848)</b>	<b>(76)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,413</b>	<b>45</b>

Facility Name & ID Number Alden of Old Town East

# 0042069

Report Period Beginning:

01/01/06

Ending:

12/31/06

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<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>93,742</u>	<u>Alden of Bloomingdale Limited Partnership</u>		\$	\$ <u>(93,742)</u>	1
2	V	<u>32 Interest Income</u>	<u>16,058</u>	<u>Alden of Bloomingdale Limited Partnership</u>			<u>(16,058)</u>	2
3	V	<u>19 Accounting Fees</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>1,500</u>	<u>1,500</u>	3
4	V	<u>19 Legal Fees: Non Collections</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>9</u>	<u>9</u>	4
5	V	<u>21 Dues &amp; Subscriptions</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>117</u>	<u>117</u>	5
6	V	<u>33 Real Estate Tax Exp</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>14,073</u>	<u>14,073</u>	6
7	V	<u>26 General Insurance Exp</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>1,383</u>	<u>1,383</u>	7
8	V	<u>36 Mortgage Insurance Premium</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>6,904</u>	<u>6,904</u>	8
9	V	<u>32 Interest Other</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>47,056</u>	<u>47,056</u>	9
10	V	<u>32 Interest IOD</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>22,379</u>	<u>22,379</u>	10
11	V	<u>30 Depreciation Exp</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>29,221</u>	<u>29,221</u>	11
12	V	<u>31 Amortization Exp</u>		<u>Alden of Bloomingdale Limited Partnership</u>		<u>602</u>	<u>602</u>	12
13	V							13
14	Total		\$ <u>109,800</u>			\$ <u>123,244</u>	\$ * <u>13,444</u>	14

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

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

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	\$ 81,676	Alden Management Services, Inc.		\$ 2,463	\$ (79,213)	15
16	V	21 Gen'l & Admin				3,200	3,200	16
17	V	5 Utilities				289	289	17
18	V	6 Rep & Maint				799	799	18
19	V	24 Travel & Seminar				186	186	19
20	V	25 Other Admin Travel				1,010	1,010	20
21	V	26 Forum Allocated Insurance				24	24	21
22	V	20 Dues, Subscriptions				216	216	22
23	V	30 Depreciation				5,278	5,278	23
24	V	31 Amortization				278	278	24
25	V	33 Real Estate Taxes				642	642	25
26	V	35 Rent-Equip. & Vehic.				3,633	3,633	26
27	V	32 Interest				9,295	9,295	27
28	V	7 Gen'l Serv Salary				4,113	4,113	28
29	V	15 Health Care Salary				3,597	3,597	29
30	V	27 G & A Salaries				40,500	40,500	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		\$ 81,676			\$ 75,523	\$ * (6,153)	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	\$ 1,018	Prism Health Care Services, Inc.		\$ 237	\$ (781)	15	
16	V	2	Tube Feeding				5,334	5,334	16	
17	V	27	G&A Salary				67	67	17	
18	V	21	G & A				52	52	18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 1,018			\$ 5,690	\$ *	4,672	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			\$	Forum Extended Care Services II, Inc.		\$		15
16	V	39	Drugs	711			998	287	16
17	V	39	Wound Care	22			17	(5)	17
18	V	4	House Stock	652			587	(65)	18
19	V	4	Pharm Consult	384			339	(45)	19
20	V	27	Employ Vaccin	500			390	(110)	20
21	V	27	G & A Salary				90	90	21
22	V	21	Gen'l & Admin				81	81	22
23	V	32	Interest				11	11	23
24	V	33	Real Estate Tax				4	4	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			\$ 2,269			\$ 4,375	\$ * 2,106	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	\$ 2,590	Community Physical Therapy & Associates, Ltd.		\$ 735	\$ (1,855)	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			\$ 2,590			\$ 742	\$ * (1,848)	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	\$ 4,994	Alden Bennett Construction Company, Inc.		\$ 4,918	\$ (76)	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			\$ 4,994			\$ 4,918	\$ *	(76) 39

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

ALDEN NURSING CENTER - OLD TOWN EAST # 42069

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 Trails	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Clinton, WI
ANC Poplar Creek	Hoffman Estates
ANC Estates of Barrington	Barrington
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 of Old Town East # 0042069 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	138,805	0.196	0.49	Salary	\$ 695	27-7	1
2	Lauren Magnusson b.	Coordinator	Nursing		81,366	0.196	0.49	Salary	399	15-7	2
3	Terry Magnusson c.	Maintenance Supr	Maint.		52,786	0.196	0.49	Salary	259	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	\$ 1,353		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 of Old Town East

# 0042069

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
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	47,056	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Related Party-FECHII	X		Working Capital							11	6								
7	Related Party-AMS	X		Working Capital							9,294	7								
8	Related Party - CPT	X		Working Capital							7	8								
9	<b>TOTAL Facility Related</b>				\$6,628.62		\$ 1,212,967	\$ 1,178,677			\$ 78,747	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>						\$ 1,212,967	\$ 1,178,677			\$ 78,747	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.)

Facility Name & ID Number Alden of Old Town East

# 0042069 Report Period Beginning: 01/01/06

Ending: 12/31/06

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																		
1. Real Estate Tax accrual used on 2005 report.		\$ 12,660	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 11,815	2															
3. Under or (over) accrual (line 2 minus line 1).		\$ (845)	3															
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 13,933	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 13,088	7															
<p>Real Estate Tax History:</p> <p>Real Estate Tax Bill for Calendar Year:</p> <table border="1"> <tr> <td>2001</td> <td>11,435</td> <td>8</td> </tr> <tr> <td>2002</td> <td>12,559</td> <td>9</td> </tr> <tr> <td>2003</td> <td>11,685</td> <td>10</td> </tr> <tr> <td>2004</td> <td>12,164</td> <td>11</td> </tr> <tr> <td>2005</td> <td>11,815</td> <td>12</td> </tr> </table> <p><u>Accrual based on approximate 3% increase over prior year bill.</u></p>		2001	11,435	8	2002	12,559	9	2003	11,685	10	2004	12,164	11	2005	11,815	12	<p>Real Estate Tax 6C: 646</p> <p>646</p> <p>13,734</p>	
2001	11,435	8																
2002	12,559	9																
2003	11,685	10																
2004	12,164	11																
2005	11,815	12																
		<b>FOR BHF USE ONLY</b>																
		13	FROM R. E. TAX STATEMENT FOR 2005 \$ 13															
		14	PLUS APPEAL COST FROM LINE 5 \$ 14															
		15	LESS REFUND FROM LINE 6 \$ 15															
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16															

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden of Old Town East COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0042069

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>02-15-201-020</u>	<u>Nursing Home Facility</u>	\$ <u>12,548.44</u>	\$ <u>12,548.44</u>
2. <u>See Attached</u>	<u>Related Party - AMS</u>	\$ <u>131,720.00</u>	\$ <u>642.00</u>
3. <u>See Attached</u>	<u>Related Party - Forum</u>	\$ <u>14,554.00</u>	\$ <u>4.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>158,822.44</u>	\$ <u>13,194.44</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 of Old Town East

# 0042069 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 6,848 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).

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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>14,400</u>	<u>1995</u>	<u>\$ 150,686</u>	1
2					2
3	<b>TOTALS</b>	<b>14,400</b>		<b>\$ 150,686</b>	<b>3</b>

**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					\$	\$		\$	\$	\$	4
5	16		1997	1997	934,861	23,372	40	23,372		199,279	5
6											6
7	Related party-Forum			1978	14,839		25			14,839	7
8											8
	<b>Improvement Type**</b>										
9	TV Modules			1999	1,775		5			1,775	9
10	Sprinkler system			2001	2,345	235	10	235		1,329	10
11	ABC-counter tops			2003	8,091	809	10	809		3,034	11
12											12
13	ABC roof repair			2003	1,685	168	10	168		519	13
14											14
15	Central States Automati(Sprinkler Repair)			2005	1,614	161	10	161		295	15
16	Alden Bennett Const(Door Installation)			2005	1,882	188	10	188		298	16
17											17
18	Painting			2006	2,675	743	3	743		743	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 969,767	\$ 25,676		\$ 25,676	\$	\$ 222,111	1
2									2
3	<b>Related Party-Forum Prof Center Building:</b>								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	<b>Related Party-AMS:</b>								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	<b>Forum Extended Care, LLC-building/building improv</b>	1999	12,434	293	30	293		2,350	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,052,147	\$ 28,321		\$ 28,321	\$	\$ 286,007	34

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

Facility Name & ID Number Alden of Old Town East # 0042069 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	\$ 123,726	\$ 11,386	\$ 11,386	\$	Various	\$ 71,916	71
72	Current Year Purchases	3,069	250	250		Various	250	72
73	Fully Depreciated Assets	73,574	1,059	1,059		Various	73,574	73
74								74
75	TOTALS	\$ 200,369	\$ 12,695	\$ 12,695	\$		\$ 145,740	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 EAST			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)	\$ 1,424,482	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,129	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,129	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)	\$ 453,140	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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning 1/1/98

Ending 6/1/06

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: \$ 4,487 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>302.75</u>	\$ <u>3,633</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>302.75</u>	\$ <u>3,633</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				998		998	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					253		253	13
14	<b>TOTAL</b>			\$		\$	\$ 1,251		\$ 1,251	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
XIV. Special Services (Direct Cost)	Col 5: PT,OT, & ST
	Col 6: Supplies

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	\$0.00
2. ST	39-3	To Col 5	418.93
3.			
4. PT	39-3	To Col 5	2,287.63
5.			
6.			
7.			
8. OT,ST,PT Reclassed			(2,706.56)
Less: DD facility, cost is moved to Line 10A			0.00
Pharmacy Supplies per GL			710.99
Manual Input from Related Party- Forum Drugs			287.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	997.99
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00
Total Exceptional Care (Line 12, Col 8)			0.00
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	
Other			1,039.38
Manual Input: Related Party - Prism			(781.00)
Manual Input: Related Party FECII - I.V.			
Wound Care-FEC II			(5.00)
13. Col 6: Supplies Total		To Col 6	253.38
13. Total Line 13, Column 8			253.38
14. Total			1,251.37

Facility Name & ID Number Alden of Old Town East# 0042069Report Period Beginning: 01/01/06Ending: 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (1,490) )	383,794	383,794	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,701	1,701	7
8	Accounts Receivable (owners or related parties)	(214,105)		8
9	Other(specify):	24,631	45,382	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 196,021	\$ 430,877	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		140,913	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	20,885	25,643	15
16	Equipment, at Historical Cost	53,432	134,602	16
17	Accumulated Depreciation (book methods)	(46,778)	(290,642)	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 (spe <b>Related Party</b> )	303,705	285,841	22
23	Other(specify): <b>Refinancing Fee, Accum Amort Refinance Fee</b>		19,927	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 331,244	\$ 1,296,397	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 527,265	\$ 1,727,274	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 80,207	\$ 78,950	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,374	3,374	28
29	Short-Term Notes Payable		10,652	29
30	Accrued Salaries Payable	42,128	42,128	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,291	2,291	31
32	Accrued Real Estate Taxes(Sch.IX-B)		12,948	32
33	Accrued Interest Payable	1,230	1,230	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>(accr ins, exps, idpa, sales tax)</b>	18,303	26,294	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 147,533	\$ 177,867	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		323,716	39
40	Mortgage Payable		844,308	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Due to Affiliates</b>	12,258	12,258	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 12,258	\$ 1,180,283	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 159,791	\$ 1,358,150	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 367,474	\$ 369,124	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 527,265	\$ 1,727,274	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 158,686	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:	52,912	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 211,598	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	155,876	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 155,876	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 367,474	24 *

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

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,166,826	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,166,826	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	<b>Prior Year A/P Adjustment &amp; Misc Income</b>	1,790	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,790	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,168,616	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	151,474	31
32	Health Care	469,551	32
33	General Administration	192,852	33
<b>B. Capital Expense</b>			
34	Ownership	127,075	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,750	35
36	Provider Participation Fee	70,038	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,012,740	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	155,876	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 155,876	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 of Old Town East

# 0042069

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	3,305	3,558	97,346	27.36	3
4	Licensed Practical Nurses	1,157	1,157	23,713	20.50	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	4,016	4,080	46,995	11.52	14
15	Cook Helpers/Assistants	164	164	1,374	8.38	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,630	1,630	14,246	8.74	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)	2,774	2,931	47,201	16.10	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	22,236	23,162	251,670	10.87	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>35,732</b>	<b>37,132</b>	<b>\$ 494,268 *</b>	<b>\$ 13.31</b>	<b>34</b>

\* 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	391	21,113	11-3	44
45	Social Service Consultant	22	1,220	11-3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>413</b>	<b>\$ 26,717</b>		<b>49</b>

**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	<b>TOTAL (lines 50 - 52)</b>		<b>\$</b>	<b>53</b>

Facility Name & ID Number Alden of Old Town East

# 0042069

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	\$ 8,972	IDPH License Fee	\$		
Latricia Davis	Administrator		2,370	Unemployment Compensation Insurance	6,713	Advertising: Employee Recruitment	1,619		
				FICA Taxes	31,401	Health Care Worker Background Check	350		
				Employee Health Insurance	5,058	(Indicate # of checks performed 35 )			
				Employee Meals	3,015	Patient Background Checks	17 170		
				Illinois Municipal Retirement Fund (IMRF)*		Related Party-AMS	216		
				Dental Ins, Life Ins, Employee Relations	86	Surety Bond, Illinois Health Care Assoc	1,957		
				Misc Payroll Costs, Employee Drug Tests	587				
				401K match, employee vaccinations	569				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 11,723	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,312			
(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	186	
							Auto/Travel & Gas Exp	1,332	
							Seminar Expense		
							Leadership Training	78	
							Ill Health Care Assoc.	100	
							Amer Express-various	373	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,069
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
AMS	Management Fees	\$ 81,675							
BDO Seidman/Reznick	Accounting Fees	3,101							
Barry Greenberg	Legal Fees: Non-Collections	2,626							
Condon 401K/Marsh USA	401k admin./various	95							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 87,497						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Alden of Old Town East

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Bill's Auto/Truck	2002	\$ 817	3	\$ 6	\$ 82	\$ 729	\$ 0	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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14													
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16													
17													
18													
19													
20	TOTALS		\$ 817		\$ 6	\$ 82	\$ 729	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Alden of Old Town East

**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. \$1927
- (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. \$ 5,176 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. \$ 70,038  
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. \$ 3,015 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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.