		FOR BHF USE					

LL1

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: 0042077

Facility Name: Alden of Old Town West

Address: 118 South Bloomingdale Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: Dupage

Telephone Number: (630)671-1660 **Fax #** (630)671-0457

HFS ID Number: 36-3966583

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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)	Steven M. Kroll
	(Title)	Chief Financial Officer
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 of Old Town West # 0042077 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	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,700			5,700	13
14	TOTALS	5,700			5,700	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.60%

D. How many bed-hold days during this year were paid by the Department?
109 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/19/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/19/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 West # 0042077 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	56,791	3,473		60,264	102	60,366		60,366			1
2	Food Purchase		34,199		34,199	(2,895)	31,304	(47)	31,257			2
3	Housekeeping	14,246	4,384		18,630		18,630		18,630			3
4	Laundry		1,049		1,049		1,049		1,049			4
5	Heat and Other Utilities			17,078	17,078		17,078	291	17,369			5
6	Maintenance			21,881	21,881		21,881	3,126	25,007			6
7	Other (specify):* Related Party Salary							4,301	4,301			7
8	TOTAL General Services	71,037	43,105	38,959	153,101	(2,793)	150,308	7,671	157,979			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	376,410	13,617	874	390,901	677	391,578	(111)	391,467			10
10a	Therapy					3,639	3,639	(2,686)	953			10a
11	Activities			23,235	23,235		23,235		23,235			11
12	Social Services	46,368			46,368		46,368		46,368			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related Party Salary							3,761	3,761			15
16	TOTAL Health Care and Programs	422,778	13,617	28,109	464,504	4,316	468,820	964	469,784			16
	C. General Administration											
17	Administrative	11,723			11,723		11,723		11,723			17
18	Directors Fees											18
19	Professional Services			96,789	96,789		96,789	(87,060)	9,729			19
20	Dues, Fees, Subscriptions & Promotions			4,891	4,891		4,891	(2,643)	2,248			20
21	Clerical & General Office Expenses		1,156	10,577	11,733		11,733	2,747	14,480			21
22	Employee Benefits & Payroll Taxes			88,228	88,228	2,116	90,344		90,344			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,180	1,180		1,180	194	1,374			24
25	Other Admin. Staff Transportation							1,055	1,055			25
26	Insurance-Prop.Liab.Malpractice			16,896	16,896		16,896	1,408	18,304			26
27	Other (specify):* Related Party Salary			2,279	2,279		2,279	39,917	42,196			27
28	TOTAL General Administration	11,723	1,156	220,840	233,719	2,116	235,835	(44,382)	191,453			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	505,538	57,878	287,908	851,324	3,639	854,963	(35,747)	819,216			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 West #0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			4,280	4,280		4,280	36,357	40,637			30
31	Amortization of Pre-Op. & Org.							892	892			31
32	Interest			24,194	24,194		24,194	54,974	79,168			32
33	Real Estate Taxes							14,608	14,608			33
34	Rent-Facility & Grounds			93,742	93,742		93,742	(93,742)				34
35	Rent-Equipment & Vehicles			4,616	4,616		4,616	3,797	8,413			35
36	Other (specify):* MIP & Amortiz.							6,904	6,904			36
37	TOTAL Ownership			126,832	126,832		126,832	23,790	150,622			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,372	3,639	5,011	(3,639)	1,372	(454)	918			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,972	77,972		77,972		77,972			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,372	81,611	82,983	(3,639)	79,344	(454)	78,890			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	505,538	59,250	496,351	1,061,139		1,061,139	(12,411)	1,048,728			45

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

From Line	To Line	Amount	Description
22		(779.00)	Uniforms
	1	102.00	Uniforms
	10	677.00	Uniforms
2		(2,895.00)	Employee Meals
	22	2,895.00	Employee Meals
39		(3,639.00)	PT/OT/ST
	10A	3,639.00	PT/OT/ST
		-	

Facility Name & ID Number Alden of Old Town West # 0042077 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(580)	21		17
18	Fines and Penalties	(761)	32		18
19	Entertainment				19
20	Contributions	(123)	20		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	(2,279)	27		24
25	Fund Raising, Advertising and Promotional	(2,109)	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)**	$ (6,393)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(324)	Various	34
35	Other- Attach Schedule **See Pg 5A**	(5,694)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,018)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (12,411)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

Alden of Old Town West

ID# 0042077

Report Period Beginning: 01/01/06

Ending: 12/31/06

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Late fees on utilities	(239)	5	2
3	Late fee on telephone	(21)	21	3
4	ADJ Real Estate Taxes to Actual	(140)	33	4
5				5
6	ADJ Defer. Maint. Exp to correct amount per sched	516	6	6
7				7
8	Intercompany interest is not allowed	(7,377)	32	8
9				9
10	Miscell Income	(47)	2	10
11				11
12				12
13				13
14	Back out 30.65% of PAC fees	(271)	20	14
15	Vendor Settlements Comed	(228)	21	15
16	Vendor Settlements Comed	228	5	16
17				17
18	Expense Capitalized items <$2,500	1,885	6	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	(5,694)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town West # 0042077 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	(47)	0	0	0	0	0	0	0	0	0	0	(47)	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	(11)	0	302	0	0	0	0	0	0	0	0	291	5
6	Maintenance	2,401	0	835	0	0	0	(110)	0	0	0	0	3,126	6
7	Other (specify):*	0	0	4,301	0	0	0	0	0	0	0	0	4,301	7
8	**TOTAL General Services**	2,343	0	5,438	0	0	0	(110)	0	0	0	0	7,671	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	(111)	0	0	0	0	0	0	(111)	10
10a	Therapy	0	0	0	0	0	(2,686)	0	0	0	0	0	(2,686)	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	3,761	0	0	0	0	0	0	0	0	3,761	15
16	**TOTAL Health Care and Programs**	0	0	3,761	0	(111)	(2,686)	0	0	0	0	0	964	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	(88,394)	0	0	0	0	0	0	0	0	(87,060)	19
20	Fees, Subscriptions & Promotions	(2,869)	0	226	0	0	0	0	0	0	0	0	(2,643)	20
21	Clerical & General Office Expenses	(829)	117	3,344	29	86	0	0	0	0	0	0	2,747	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	194	0	0	0	0	0	0	0	0	194	24
25	Other Admin. Staff Transportation	0	0	1,055	0	0	0	0	0	0	0	0	1,055	25
26	Insurance-Prop.Liab.Malpractice	0	1,383	25	0	0	0	0	0	0	0	0	1,408	26
27	Other (specify):*	(2,279)	0	42,180	37	(21)	0	0	0	0	0	0	39,917	27
28	**TOTAL General Administration**	(6,152)	3,009	(41,370)	66	65	0	0	0	0	0	0	(44,382)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,809)	3,009	(32,171)	66	(46)	(2,686)	(110)	0	0	0	0	(35,747)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town West # 0042077 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	290	0	0	0	0	0	0	0	0	892	31
32	Interest	(8,138)	53,377	9,714	0	12	9	0	0	0	0	0	54,974	32
33	Real Estate Taxes	(140)	14,073	671	0	4	0	0	0	0	0	0	14,608	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	3,797	0	0	0	0	0	0	0	0	3,797	35
36	Other (specify):*	0	6,904	0	0	0	0	0	0	0	0	0	6,904	36
37	**TOTAL Ownership**	(8,278)	10,435	19,750	0	1,874	9	0	0	0	0	0	23,790	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	(453)	(1)	0	0	0	0	0	0	(454)	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	(453)	(1)	0	0	0	0	0	0	(454)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,087)	13,444	(12,421)	(387)	1,827	(2,677)	(110)	0	0	0	0	(12,411)	45

Facility Name & ID Number Alden of Old Town West # 0042077 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
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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Exp		Alden of Bloomingdale Limited Partnership		14,073	14,073	6
7	V	26	General Insurance Premium		Alden of Bloomingdale Limited Partnership		1,383	1,383	7
8	V	36	Mortgage Insurance proemium		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 Expense		Alden of Bloomingdale Limited Partnership		29,221	29,221	11
12	V	31	Amortization Expense		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 of Old Town West # 0042077 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. [x] 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	$ 90,968	Alden Management Services, Inc.		$ 2,574	$ (88,394)	15
16	V	21	Gen'l & Admin				3,344	3,344	16
17	V	5	Utilities				302	302	17
18	V	6	Rep & Maint				835	835	18
19	V	24	Travel & Seminar				194	194	19
20	V	25	Other Admin Travel				1,055	1,055	20
21	V	26	Forum Allocated Insurance				25	25	21
22	V	20	Dues, Subscriptions				226	226	22
23	V	30	Depreciation				5,278	5,278	23
24	V	31	Amortization				290	290	24
25	V	33	Real Estate Taxes				671	671	25
26	V	35	Rent-Equip & Vehic				3,797	3,797	26
27	V	32	Interest				9,714	9,714	27
28	V	7	Gen'l Serv Salary				4,301	4,301	28
29	V	15	Health Care Salary				3,761	3,761	29
30	V	27	G & A Salaries				42,180	42,180	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			$ 90,968			$ 78,547	$ * (12,421)	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 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. [x] 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	$ 562	Prism Health Care Services, Inc.		$ 109	$ (453)	15
16	V	27	G&A: Salary				37	37	16
17	V	21	G&A				29	29	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			$ 562			$ 175	$ * (387)	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 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. [x] 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	284			398	114	16
17	V	39	Wound Care	527			412	(115)	17
18	V	10	House Stock	669			603	(66)	18
19	V	10	Pharm Consult	384			339	(45)	19
20	V	27	Employ Vaccin	536			419	(117)	20
21	V	27	G & A Salary				96	96	21
22	V	21	Gen'l & Admin				86	86	22
23	V	32	Interest				12	12	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			$ 2,400			$ 4,227	$ * 1,827	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 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. [x] 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	$ 3,639	Community Physical Therapy & Associates, Ltd.		$ 953	$ (2,686)	15
16	V	32	Interest				9	9	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			$ 3,639			$ 962	$ * (2,677)	39

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

Facility Name & ID Number Alden of Old Town West # 0042077 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. [x] 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	$ 7,220	Alden Bennett Construction Company, Inc.		$ 7,110	$ (110)	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			$ 7,220			$ 7,110	$ * (110)	39

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

Facility Name & ID Number ALDEN NURSING CENTER - OLD TOWN WEST # 004-2007 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	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Northmoor	Chicago
ANC Princeton	Chicago
Alden Orland Park	Orland Park
Alden of Old Town East	Bloomingdale
Alden Trails	Bloomingdale
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	Bloomingdale

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 West # 0042077 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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Floyd A. Schlossberg a.	President	President	100.00	138,789	0.204	0.51	Salary	$ 711	27-7	1
2	Lauren Magnusson b.	Coordinator	Nursing		81,348	0.204	0.51	Salary	417	15-7	2
3	Terry Magnusson c.	Maintenance Supr	Maint.		52,775	0.204	0.51	Salary	270	7-7	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of The Alden Group, Ltd										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	$ 1,398		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 West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	47,056	2
3												3
4												4
5												5
	Working Capital											
6	Related Party-FECII	X		Working Capital							11	6
7	Related Party-AMS	X		Working Capital							9,713	7
8	Related Party - CPT	X		Working Capital							9	8
9	TOTAL Facility Related				$6,628.62		$ 1,212,967	$ 1,178,677			$ 79,168	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			$ 79,168	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 West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.	$ 13,342	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.)	$ 12,660	2
3. Under or (over) accrual (line 2 minus line 1).	$ (682)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 14,615	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 13,933	7

Real Estate Tax 6C: 675 675

Real Estate Tax History: 14,608

Real Estate Tax Bill for Calendar Year:

2001	12,114	8
2002	13,304	9
2003	12,378	10
2004	12,886	11
2005	12,660	12

Accrual based on 3% increase over prior yr bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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 West COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0042077

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-112-007	Nursing Home Facility	$ 13,293.00	$ 13,293.00
2.	See Attached	Related Party - AMS	$ 131,720.00	$ 671.00
3.	See Attached	Related Party - Forum	$ 14,554.00	$ 4.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 159,567.00	$ 13,968.00

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 comsidered 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 West # 0042077 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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Building	18,000	1995	$ 150,868	1
2					2
3	TOTALS	18,000		$ 150,868	3

Facility Name & ID Number Alden of Old Town West # 0042077 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 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		1998	1998	934,861	23,372	40	23,372		175,909	5
6											6
7	Related party-Forum			1978	14,839		25			14,839	7
8											8
	Improvement Type**										
9	Sprinkler system			1999	1,510	101	15	101		797	9
10	ABC-counter tops			2004	8,102	810	10	810		3,038	10
11											11
12											12
13											13
14	ABC-Installed Dining Room Flooring			2005	5,421	361	15	361		512	14
15	ABC-Kitchen Repairs			2005	6,146	410	15	410		615	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 of Old Town West # 0042077 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 970,879	$ 25,053		$ 25,053	$	$ 195,710	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)		$ 1,053,258	$ 27,699		$ 27,699	$	$ 259,606	34

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

Facility Name & ID Number Alden of Old Town West # 0042077 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	$ 117,260	$ 11,427	$ 11,427	$	Various	$ 69,402	71
72	Current Year Purchases	2,086	168	168		Various	168	72
73	Fully Depreciated Assets	75,349	1,230	1,230		Various	75,349	73
74								74
75	TOTALS	$ 194,695	$ 12,825	$ 12,825	$		$ 144,919	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 West			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)	$ 1,420,101	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,637	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,637	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)	$ 425,918	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 [X] NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

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.	/2007	$ Varies
13.	/2008	$ Varies
14.	/2009	$ Varies

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 4,616 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	Related Party AMS		$ 316.42	$ 3,797	17
18					18
19					19
20					20
21	TOTAL		$ 316.42	$ 3,797	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.

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled Nursing On-Site

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	$			

(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.

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	

(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.

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

		1	2	3	4	5	6	7	8	
	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				398		398	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					520		520	13
14	TOTAL			$		$	$ 918		$ 918	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.

XIV. Special Services (Direct Cost)			Page 16 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	469.91
3.			
4. PT	39-3	To Col 5	3,169.54
5.			
6.			
7.			
8.			
Less: move PT, OT, & ST to Ln 10A for DD type entities			(3,639.45)
Phamacy Supplies per GL			283.75
Manual Input from Related Party- Forum Drugs			115.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	398.75
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		0.00
13. Col 5: Manual Input: Related Party		To Col 5	
Other			1,088.67
Manual Input: Related Party - Prism			(453.00)
Manual Input: Related Party FECII - I.V.			
Manual Input: Related Party FECII - Wound Care			(115.00)
13. Col 6: Supplies Total		To Col 6	520.67
13. Total Line 13, Column 8			520.67
14. Total			919.42

Facility Name & ID Number Alden of Old Town West # 0042077 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 (500))	489,190	489,190	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)	(242,508)		8
9	Other(specify): Due from 3rd parties	27,732	48,483	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 276,115	$ 539,374	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		141,874	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	25,947	30,705	15
16	Equipment, at Historical Cost	51,898	131,541	16
17	Accumulated Depreciation (book methods)	(47,435)	(290,433)	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):	569,488	549,796	22
23	Other(specify): Refinance Fee, Accum Amortiz-Refinance Fee		19,927	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 599,898	$ 1,563,523	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 876,013	$ 2,102,897	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 69,958	$ 87,137	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,930	1,930	28
29	Short-Term Notes Payable		10,652	29
30	Accrued Salaries Payable	55,887	55,887	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,802	3,802	31
32	Accrued Real Estate Taxes(Sch.IX-B)		14,615	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	IDPA, Accrued Ins, Accrued Exp	20,761	27,225	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 153,568	$ 202,478	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	Due to Affiliates	10,246	10,246	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,246	$ 1,178,270	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 163,814	$ 1,380,748	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 712,199	$ 722,149	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 876,013	$ 2,102,897	48

*(See instructions.)

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 543,843	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	(70,099)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 473,744	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	238,455	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)**	$ 238,455	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)**	$ 712,199	24 *

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

Facility Name & ID Number Alden of Old Town West # 0042077 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,299,541	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,299,541	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	Misc Inc, Prior Year Exp Adj	53	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 53	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,299,594	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	153,101	31
32	Health Care	464,504	32
33	General Administration	233,719	33
	B. Capital Expense		
34	Ownership	126,832	34
	C. Ancillary Expense		
35	Special Cost Centers	5,011	35
36	Provider Participation Fee	77,972	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,061,139	40
41	**Income before Income Taxes (line 30 minus line 40)****	238,455	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 238,455	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 West # 0042077 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	2,619	3,050	97,346	31.92	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	2,448	2,456	29,386	11.96	14
15	Cook Helpers/Assistants	2,217	2,217	27,406	12.36	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,576	1,576	14,246	9.04	18
19	Laundry					19
20	Administrator	676	725	11,723	16.17	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)	2,750	2,774	46,368	16.72	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	23,185	23,970	255,350	10.65	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	36,628	37,925	$ 505,538 *	$ 13.33	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	403	21,777	11-3	44
45	Social Service Consultant	27	1,459	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	430	$ 27,620		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 of Old Town West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Allison	Administrator		$ 9,353
Latricia Davis	Administrator		2,370
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 11,723

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
AMS	Management Fees	$ 90,968
BDO Seidman/Reznick	Accounting Fees	3,101
Barry Greenberg	Legal Fees: Non-Collections	2,625
Condon /Marsh USA	401k admin/various consulting s	95
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 96,789

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,320
Unemployment Compensation Insurance	20,260
FICA Taxes	39,759
Employee Health Insurance	12,910
Employee Meals	2,895
Illinois Municipal Retirement Fund (IMRF)*	
Dental Ins, Life Ins, Misc Payroll Costs	424
Employee Drug Tests, Employee Vaccinations	776
TOTAL (agree to Schedule V, line 22, col.8)	$ 90,344

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	106
Health Care Worker Background Check	140
(Indicate # of checks performed 14)	
Patient Background Checks 17	170
Related Party AMS	226
Surety Bond, Illinois Health Care Assoc&Ext	1,606
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,248

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party AMS	194
Gas Exp	1,074
Seminar Expense	
Leadership Training	78
Seminars/Conventions	28
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,374

**See instructions.

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	Painting	10/03	$ 2,065	3	$ 172	$ 688	$ 688	$ 516	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,065		$ 172	$ 688	$ 688	$ 516	$	$	$	$	$

Facility Name & ID Number **Alden of Old Town West** **# 0042077** **Report Period Beginning: 01/01/06** **Ending: 12/31/06**

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. $1527**

(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? **15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,394** 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. $ **77,975**
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. $ **2,895** 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 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.