

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0042010

Facility Name: Alden Des Plaines Rehab & HC

Address: 1221 East Golf Road Des Plaines 60016
 Number City Zip Code

County: Cook

Telephone Number: (847) 768-1300 **Fax #** (847) 768-1668

HFS ID Number: 36-4271650

Date of Initial License for Current Owners: 10/31/2000

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Joan Carl</u>	
	(Title) <u>Vice-President</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010 Report Period Beginning: 1/1/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</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	Total	
8	SNF	<u>709</u>	<u>5,502</u>	<u>19,528</u>	<u>25,739</u>	8
9	SNF/PED					9
10	ICF	<u>405</u>	<u>617</u>		<u>1,022</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,114</u>	<u>6,119</u>	<u>19,528</u>	<u>26,761</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.65%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started 10/31/2000

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

YES Date 10/31/2000 NO

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

YES NO If YES, enter number of beds certified 110 and days of care provided 19,528

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	474,352	33,440	8,823	516,615	618	517,233	553	517,786		1
2	Food Purchase		218,785		218,785	(19,639)	199,146	(9,213)	189,933		2
3	Housekeeping	161,862	28,655		190,517	524	191,041	2,165	193,206		3
4	Laundry	26,470	11,892	186	38,548	33	38,581		38,581		4
5	Heat and Other Utilities			210,494	210,494		210,494	(3,820)	206,674		5
6	Maintenance	44,302		151,759	196,061	90	196,151	17,340	213,491		6
7	Other (specify):* Related Party			150	150		150	4,017	4,167		7
8	TOTAL General Services	706,986	292,772	371,412	1,371,170	(18,374)	1,352,796	11,042	1,363,838		8
	B. Health Care and Programs										
9	Medical Director			54,000	54,000		54,000		54,000		9
10	Nursing and Medical Records	2,186,398	172,097	12,465	2,370,960	12,298	2,383,258	74,872	2,458,130		10
10a	Therapy	45,268			45,268		45,268		45,268		10a
11	Activities	87,430	1,905	1,981	91,316	71	91,387		91,387		11
12	Social Services	40,541			40,541		40,541		40,541		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party							4,579	4,579		15
16	TOTAL Health Care and Programs	2,359,637	174,002	68,446	2,602,085	12,369	2,614,454	79,451	2,693,905		16
	C. General Administration										
17	Administrative	69,057			69,057		69,057	35,409	104,466		17
18	Directors Fees										18
19	Professional Services			966,735	966,735	(13,697)	953,038	(911,513)	41,525		19
20	Dues, Fees, Subscriptions & Promotions			92,442	92,442	(600)	91,842	(79,508)	12,334		20
21	Clerical & General Office Expenses	269,946	25,365	68,426	363,737	5,591	369,328	47,928	417,256		21
22	Employee Benefits & Payroll Taxes			477,072	477,072	14,711	491,783	(20,109)	471,674		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,792	7,792		7,792	1,262	9,054		24
25	Other Admin. Staff Transportation			1,908	1,908		1,908	6,476	8,384		25
26	Insurance-Prop.Liab.Malpractice			106,595	106,595	(500)	106,095	13,343	119,438		26
27	Other (specify):* Related Party			57,170	57,170		57,170	(23,930)	33,240		27
28	TOTAL General Administration	339,003	25,365	1,778,140	2,142,508	5,505	2,148,013	(930,642)	1,217,371		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,405,626	492,139	2,217,998	6,115,763	(500)	6,115,263	(840,149)	5,275,114		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 Des Plaines Rehab & HC #0042010 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			49,764	49,764		49,764	226,526	276,290		30
31	Amortization of Pre-Op. & Org.							35	35		31
32	Interest			307,332	307,332	500	307,832	281,033	588,865		32
33	Real Estate Taxes							353,941	353,941		33
34	Rent-Facility & Grounds			1,424,987	1,424,987		1,424,987	(1,424,987)			34
35	Rent-Equipment & Vehicles			8,167	8,167		8,167	19,580	27,747		35
36	Other (specify):*							51,837	51,837		36
37	TOTAL Ownership			1,790,250	1,790,250	500	1,790,750	(492,035)	1,298,715		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		890,378	1,578,739	2,469,117		2,469,117	(104,845)	2,364,272		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			60,225	60,225		60,225		60,225		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		890,378	1,638,964	2,529,342		2,529,342	(104,845)	2,424,497		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,405,626	1,382,517	5,647,212	10,435,355		10,435,355	(1,437,029)	8,998,326		45

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

Reporting Period Beginning 1/1/2007

Reporting Period Ending 12/31/2007

Reclassifications - Pgs 3 and 4

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(19,639.00)	Employee Meals
	22	19,639.00	
26		(500.00)	Insurance Expense
	32	500.00	
22		(4,928.00)	Employee Uniforms
	1	618.00	
	3	524.00	
	4	33.00	
	6	90.00	
	10	3,360.00	
	11	71.00	
	21	232.00	
20		(600.00)	eHealth Data Solution
	21	600.00	
19		(8,938.00)	Pathway-Clinical consultant
	10	8,938.00	
19		(4,759.00)	Hendrich Blessing
	21	4,759.00	
		<hr/>	
		-	

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 1/1/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF 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	(90,935)	30		9
10	Interest and Other Investment Income	(1,452)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,652)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,711)	21		17
18	Fines and Penalties	(14,726)	32		18
19	Entertainment	(821)	20		19
20	Contributions	(3,903)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,754)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,170)	27		24
25	Fund Raising, Advertising and Promotional	(28,533)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,637)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (220,294)		\$	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)	(783,684)	Various	34
35	Other- Attach Schedule	(433,051)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,216,735)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,437,029)		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			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Alden Des Plaines Rehab & HC

ID# 0042010

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late fees on utilities	\$ (5,357)	5	1
2	Intercompany Interest (7031)	(101,720)	32	2
3	Employee Exp. (g/l 4977-100-000)	(66)	22	3
4	Record Copies (g/l 4977-100-001)	(529)	10	4
5	Food Rebate (g/l 4977-100-005)	(1,148)	2	5
6	Wage Service Fee (g/l 4977-100-006)	(48)	21	6
7	Jury Duty (g/l 4977-100-002)	(58)	21	7
8	Marketing Mgr (g/l 6701-100-009)	(139,525)	21	8
9	Mktg Mgr employee benefits reduction	(19,677)	22	9
10	IL Health Care Assoc Dues (PAC: 29.31%)	(1,780)	20	10
11	Add vendor settlement cost (g/l 7143) to reclass	(6,223)	21	11
12	Back out vendor settlement credit for Chemcraft	20	6	12
13	Back out vendor settlement credit for Call One	1,000	21	13
14	Back out vendor settlement credit for Shalom Landscapin	50	6	14
15	Back out vendor settlement credit for R. Czeck	5,153	6	15
16	Back out LLC mtge int > CON asset limit	(146,898)	32	16
17	Back out LLC MIP exp > CON asset limit	(18,052)	36	17
18	Back out LLC bank charges	(260)	21	18
19	Expense assets < \$2,500	15,473	6	19
20	Back out depreciation on assets < \$2,500	(5,196)	30	20
21	Adjust depreciation to Pg 13's	0	30	21
22	Eliminate non-care employee benefits	(366)	22	22
23	Eliminate non-care marketing costs	(2,587)	20	23
24	Eliminate non-care G & A costs	(261)	21	24
25	Eliminate non-care R & M costs	(261)	6	25
26	Backout PAC - Dinner	(150)	24	26
27	Deming Leadership Training (0.0306)	174	24	27
28	Eliminate Hedrich Blessing Photography	(4,759)	19	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	(433,051)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,105	(2,552)	0	0	0	0	0	0	0	553	1
2	Food Purchase	(2,800)	0	0	(6,413)	0	0	0	0	0	0	0	(9,213)	2
3	Housekeeping	0	0	2,165	0	0	0	0	0	0	0	0	2,165	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,357)	0	1,537	0	0	0	0	0	0	0	0	(3,820)	5
6	Maintenance	20,435	0	(2,856)	0	0	0	(239)	0	0	0	0	17,340	6
7	Other (specify):*	0	0	3,474	543	0	0	0	0	0	0	0	4,017	7
8	TOTAL General Services	12,278	0	7,425	(8,422)	0	0	(239)	0	0	0	0	11,042	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	(529)	0	72,821	1,707	873	0	0	0	0	0	0	74,872	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	4,579	0	0	0	0	0	0	0	0	4,579	15
16	TOTAL Health Care and Programs	(529)	0	77,400	1,707	873	0	0	0	0	0	0	79,451	16
	C. General Administration													
17	Administrative	0	0	35,409	0	0	0	0	0	0	0	0	35,409	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,513)	4,850	(895,850)	0	0	0	0	0	0	0	0	(911,513)	19
20	Fees, Subscriptions & Promotions	(40,261)	0	(39,247)	0	0	0	0	0	0	0	0	(79,508)	20
21	Clerical & General Office Expenses	(148,086)	617	130,163	12,087	53,147	0	0	0	0	0	0	47,928	21
22	Employee Benefits & Payroll Taxes	(20,109)	0	0	0	0	0	0	0	0	0	0	(20,109)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	24	0	1,238	0	0	0	0	0	0	0	0	1,262	24
25	Other Admin. Staff Transportation	0	0	6,476	0	0	0	0	0	0	0	0	6,476	25
26	Insurance-Prop.Liab.Malpractice	0	13,229	114	0	0	0	0	0	0	0	0	13,343	26
27	Other (specify):*	(57,170)	0	28,835	1,129	3,276	0	0	0	0	0	0	(23,930)	27
28	TOTAL General Administration	(286,115)	18,696	(732,862)	13,216	56,423	0	0	0	0	0	0	(930,642)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(274,366)	18,696	(648,037)	6,501	57,296	0	(239)	0	0	0	0	(840,149)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(96,131)	317,904	3,226	0	1,527	0	0	0	0	0	0	226,526	30
31	Amortization of Pre-Op. & Org.	0	0	35	0	0	0	0	0	0	0	0	35	31
32	Interest	(264,796)	535,171	7,168	0	3,023	467	0	0	0	0	0	281,033	32
33	Real Estate Taxes	0	350,588	2,370	0	983	0	0	0	0	0	0	353,941	33
34	Rent-Facility & Grounds	0	(1,424,987)	0	0	0	0	0	0	0	0	0	(1,424,987)	34
35	Rent-Equipment & Vehicles	0	0	19,580	0	0	0	0	0	0	0	0	19,580	35
36	Other (specify):*	(18,052)	69,889	0	0	0	0	0	0	0	0	0	51,837	36
37	TOTAL Ownership	(378,979)	(151,435)	32,379	0	5,533	467	0	0	0	0	0	(492,035)	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	(45,490)	(124,326)	64,971	0	0	0	0	0	(104,845)	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	(45,490)	(124,326)	64,971	0	0	0	0	0	(104,845)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(653,345)	(132,739)	(615,658)	(38,989)	(61,497)	65,438	(239)	0	0	0	0	(1,437,029)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6L		See Pg 6K		See Pg 6K		

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

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

1 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	\$ 1,424,987	Alden-Des Plaines Rehabilitation and Health Care Center, LLC		\$	\$ (1,424,987)	1
2	V	32 Interest-Replacement reserve	3,875	Alden-Des Plaines Rehabilitation and Health Care Center, LLC			(3,875)	2
3	V	32 Interest - facility loan	68,892	Alden-Des Plaines Rehabilitation and Health Care Center, LLC			(68,892)	3
4	V	19 Accounting/Prof Fees		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		4,850	4,850	4
5	V	21 Bank charges		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		260	260	5
6	V	21 Licenses, etc		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		357	357	6
7	V	33 Real estate taxes		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		350,588	350,588	7
8	V	26 Property & liability ins		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		13,229	13,229	8
9	V	36 Mortgage insurance		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		64,470	64,470	9
10	V	32 Interest on mortgage		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		524,634	524,634	10
11	V	32 Interest on IOD loan		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		83,304	83,304	11
12	V	30 Depreciation		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		317,904	317,904	12
13	V	36 Amortization		Alden-Des Plaines Rehabilitation and Health Care Center, LLC		5,419	5,419	13
14	Total		\$ 1,497,754			\$ 1,365,015	\$ * (132,739)	14

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

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 1/1/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional fees	\$ 919,264	Alden Management Services, Inc.	0.00%	\$ 23,414	\$ (895,850)	15
16	V	21 Clerical and G & A		Alden Management Services, Inc.		130,163	130,163	16
17	V	5 Utilities		Alden Management Services, Inc.		1,537	1,537	17
18	V	6 Maintenance	22,678	Alden Management Services, Inc.		19,822	(2,856)	18
19	V	24 Travel & seminar		Alden Management Services, Inc.		1,238	1,238	19
20	V	25 Other admin travel		Alden Management Services, Inc.		6,476	6,476	20
21	V	26 Insurance		Alden Management Services, Inc.		114	114	21
22	V	20 Dues/subscriptions/fees etc	39,510	Alden Management Services, Inc.		263	(39,247)	22
23	V	30 Depreciation		Alden Management Services, Inc.		3,226	3,226	23
24	V	31 Amortization		Alden Management Services, Inc.		35	35	24
25	V	33 Real estate taxes		Alden Management Services, Inc.		2,370	2,370	25
26	V	35 Rent-equipment/vehicles		Alden Management Services, Inc.		19,580	19,580	26
27	V	32 Interest		Alden Management Services, Inc.		7,168	7,168	27
28	V	1 Salaries-Dietary Aide		Alden Management Services, Inc.		3,105	3,105	28
29	V	15 Employee Benefits-health care		Alden Management Services, Inc.		4,579	4,579	29
30	V	27 Employee Benefits-general admin		Alden Management Services, Inc.		28,835	28,835	30
31	V	3 Salaries-Housekeeping Coord.		Alden Management Services, Inc.		2,165	2,165	31
32	V	7 Employee Benefits-general Svcs		Alden Management Services, Inc.		3,474	3,474	32
33	V	10 Salaries-Nurse & Med. Records		Alden Management Services, Inc.		72,821	72,821	33
34	V	17 Salaries-Total Admin		Alden Management Services, Inc.		35,409	35,409	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 981,452			\$ 365,794	\$ * (615,658)	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	1 Dietary consultant	\$ 8,823	Prism Health Care Services, Inc.	0.00%	\$ 3,032	\$ (5,791)	15
16	V	1 Dietary salaries		Prism Health Care Services, Inc.		3,239	3,239	16
17	V	2 Tube feeding	13,893	Prism Health Care Services, Inc.		7,480	(6,413)	17
18	V	10 Equipment rental-patient care	3,060	Prism Health Care Services, Inc.		4,767	1,707	18
19	V	39 Ancillary supplies	85,386	Prism Health Care Services, Inc.		39,896	(45,490)	19
20	V	21 G & A salaries		Prism Health Care Services, Inc.		4,810	4,810	20
21	V	21 G & A expenses		Prism Health Care Services, Inc.		7,277	7,277	21
22	V	27 Emp. Benefits-G & A		Prism Health Care Services, Inc.		1,129	1,129	22
23	V	7 Emp. Benefits-Dietary		Prism Health Care Services, Inc.		543	543	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		\$ 111,162			\$ 72,173	\$ * (38,989)	39

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

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 1/1/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39	Drugs	\$ 421,544	Forum Extended Care Services II, Inc.	0.00%	\$ 625,242	\$ 203,698	15
16	V	39	I.V.	368,115	Forum Extended Care Services II, Inc.		40,387	(327,728)	16
17	V	39	Wound Vac	1,441	Forum Extended Care Services II, Inc.		1,145	(296)	17
18	V	10	House Stock	10,594	Forum Extended Care Services II, Inc.		10,110	(484)	18
19	V	10	Pharm Consult	3,940	Forum Extended Care Services II, Inc.		5,297	1,357	19
20	V	27	Employ Vaccin	2,229	Forum Extended Care Services II, Inc.		1,748	(481)	20
21	V	27	Employ Benefits-G & A		Forum Extended Care Services II, Inc.		3,757	3,757	21
22	V	21	G & A Salaries		Forum Extended Care Services II, Inc.		28,513	28,513	22
23	V	21	Gen'l & Admin		Forum Extended Care Services II, Inc.		24,634	24,634	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		3,023	3,023	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		983	983	25
26	V	30	Depreciation		Forum Extended Care Services II, Inc.		1,527	1,527	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		\$ 807,863				\$ 746,366	\$ * (61,497)	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	Revenue - therapy	\$ 1,488,820	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,553,791	\$ 64,971	15
16	V	32	Interest		Community Physical Therapy & Associates, Ltd.		467	467	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,488,820			\$ 1,554,258	\$ * 65,438	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & maintenance	\$ 17,536	Alden Bennett Construction Company, Inc.	0.00%	\$ 17,297	\$ (239)	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			\$ 17,536			\$ 17,297	\$ * (239)	39

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

STATE OF ILLINIOS

Facility Name & ID Number Alden Des Plaines Rehab & HC Provider No. 0042010 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

Reporting Period Beginning 1/1/2007
 Reporting Period Ending 12/31/2007

Investor List

				<u>Percent</u>
Dr.	Julian	E.	Bailes	1
Mr. & Mrs	Harvey		Brin	1
Mr. & Mrs.	Robert		Caras	1
Mr. & Mrs.	Ronald		Caras	1
Mr.	Aaron		Carl	1
Mr. & Mrs.	Brett		Carl	1
Mr.	Sam		Carl	9
Mr.	Scott		Casty	10
Mr. & Mrs.	Jeffery		Deldin	1
Mr.	Ross		Deutsch	1
Mrs.	Audra		Elisco	1
Mr.	James		Frey	2
Mr & Mrs.	Joseph		Garcia	2
Mr. & Mrs	Kenneth		Goldsand	1
Mr.	Stuart		Goldsand	4
Ms.	Jamie		Goldsand-Sulliv	1
Ms.	Teri	G.	Hall	1
Mr.	James	P.	Hallberg	3
Mr.	Hershel		Herrendorf	1
Mr.	William		Holway	2
Mr.	Robert		Haworth	1
Mr.	Richard		Kern	1
Mr. & Mrs.	Gary		Lev	2
Mrs.	Lauren		Magnusson	1
Mr.	David		Menn	1
Mr.	Ami		Pissetzky	1
Mr.	Floyd		Schlossberg	36
Mrs.	Mildred		Schlossberg	5
Ms.	Randi		Schullo	2
Mr.	Ritchie		Schullo	2
Mr.	John	A.	Vercillo	3

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 1/1/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	CEO	37.00	167,037	0.928	0.02	Salary	\$ 3,963	17-7	1
2	Lauren Magnusson b.	Dir. Of Clinical Servi	Technical Nursing	0.50	62,986	0.928	0.02	Salary	1,494	10-7	2
3	Terry Magnusson c.	Dir. of Purchasing	Supervise Mainten	0.50	37,080	0.928	0.02	Salary	880	6-7	3
4	Joan Carl d.	Vice-President/Secret	Vice-President	9.00	167,037	0.928	0.02	Salary	3,963	17-7	4
5	Ami Pissetzky e.	Director of Finance	Invest/Banking	1.00	167,037	0.928	0.02	Salary	3,963	17-7	5
6											6
7	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										8
9	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers.										9
10	D. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12	E. Ami Pissetzky is the Director of Finance. He has an interest in the real estate of Des Plaines.										12
13								TOTAL	\$ 14,263		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 Des Plaines Rehab & HC

0042010

Report Period Beginning: 1/1/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773)286-3883
 Fax Number (773)286-8038

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,154,703	29	\$ 66,329	\$ 26,761	\$ 1,537	1
2	24	Travel & Seminar	Patient Days	1,154,703	29	53,403	26,761	1,238	2
3	25	Other Admin Travel	Patient Days	1,154,703	29	279,431	26,761	6,476	3
4	26	Insurance	Patient Days	1,154,703	29	4,925	26,761	114	4
5	20	Dues & Subscription	Patient Days	1,154,703	29	11,328	26,761	263	5
6	30	Depreciation	Patient Days	29	29	93,554	1	3,226	6
7	31	Amortization	Patient Days	1,154,703	29	1,500	26,761	35	7
8	33	Real estates Tax	Patient Days	1,154,703	29	102,244	26,761	2,370	8
9	35	Rent - Equip & Vehicles	Patient Days	1,154,703	29	844,835	26,761	19,580	9
10	32	Interest	Patient Days	1,154,703	29	309,290	26,761	7,168	10
11	1	Dietary	Patient Days	1,154,703	29	133,965	133,965	3,105	11
12	3	Housekeeping	Patient Days	1,154,703	29	93,421	93,421	2,165	12
13	7	Employee benefits - Gen'l Srvc	Patient Days	1,154,703	29	149,914	26,761	3,474	13
14	10	Nurs & Med Records Salary	Patient Days	1,154,703	29	3,142,133	1,178,420	72,821	14
15	15	Employee benefits - Health care	Patient Days	1,154,703	29	197,574	26,761	4,579	15
16	17	Administrative Salary	Patient Days	1,154,703	29	1,527,863	1,091,420	35,409	16
17									17
18	27	Employee benefits - Admin	Patient Days	1,154,703	29	1,244,181	26,761	28,835	18
19	19	Professional Fees	Patient Days	1,154,703	29	1,010,272	531,592	23,414	19
20	21	Gen'l & Admin	Patient Days	1,154,703	29	5,616,348	4,942,836	130,163	20
21	6	Repair & Maintenance	Patient Days	1,154,703	29	855,298	666,770	19,822	21
22									22
23									23
24									24
25	TOTALS					\$ 15,737,808	\$ 8,638,424	\$ 365,794	25

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	Cambridge Realty		X	Mortgage	\$53,475.00	9/1/2005	\$ 10,390,300	\$ 10,205,428	4/1/2044	5.4000	\$ 524,634	1
2	Cambridge Realty		X	Operating loss loan		3/1/2004	1,690,000		6/1/2040	5.1000	83,304	2
3				Int exp in excess of CON cap							(146,898)	3
4	Bank Leumi		X	Working capital	varies	3/29/2006	1,500,000	1,329,000	8/1/2008	varies	121,994	4
5	Insurance Interest-see reclass		x	Malpractice Ins Interest							500	5
Working Capital												
6	Related Party - CPT	X		Working Capital							467	6
7	Related Party - AMS	X		Working capital							7,168	7
8	Related Party - FECII	X		Working Capital							3,023	8
9	TOTAL Facility Related				\$53,475.00		\$ 13,580,300	\$ 11,534,428			\$ 594,192	9
B. Non-Facility Related*												
10	DP Rehab & HCC, LCC	X		Interest-Replacement Res							(3,875)	10
11	Patient interest income		X	Non-care interest income							(1,452)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (5,327)	14
15	TOTALS (line 9+line14)						\$ 13,580,300	\$ 11,534,428			\$ 588,865	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 64,470 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Des Plaines Rehab & HC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042010

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286-3883 FAX #: (773)286-8038

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>See Attached (12 Pg Supplement)</u>	<u>Related Party-Alden Management Serv</u>	\$ <u>241,399.00</u>	\$ <u>2,370.00</u>
2. <u>See Attached (12 Pg Supplement)</u>	<u>Related Party-Forum Professional Cen</u>	\$ <u>37,806.00</u>	\$ <u>983.00</u>
3. <u>09-17-200-128-0000</u>	<u>Nursing home facility</u>	\$ <u>173,044.41</u>	\$ <u>173,044.41</u>
4. <u>09-17-200-129-0000</u>	<u>Nursing home facility</u>	\$ <u>121,143.87</u>	\$ <u>121,143.87</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>573,393.28</u>	\$ <u>297,541.28</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Des Plaines Rehab & HC

0042010 Report Period Beginning:

1/1/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,490 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing home</u>	<u>51,490</u>	<u>2000</u>	<u>\$ 1,016,045</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	51,490		\$ 1,016,045	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	110		2000	2000	9,685,956	242,149	40	174,652	(67,497)	\$ 1,334,534	4
5	Adjustment to correct to CON costs (net=6,986,060)				(2,699,896)						5
6											6
7											7
8	Related Party-Forum			1978	14,541		25			14,541	8
	Improvement Type**										
9	ISS/Chicago Sound & Communication(vent alarm interface)			2000	3,400	340	10	340		2,607	9
10	Alden Bennett Construction(multiple wireless install)			2001	4,894	489	10	489		3,262	10
11	Owners extras (change orders)			2000	524,876	26,244	20	26,244		194,642	11
12	Owners extras (change orders)			2000	12,972	648	20	648		4,810	12
13	ABC-parking lot sealcoat/stripe			2002	3,852	550	7	550		2,981	13
14	ABC-screened patio enclosure			2002	10,069	1,438	7	1,438		8,390	14
15	EWS Welding-alarm			2002	1,076	108	10	108		646	15
16	New Horizons-residents phones			2002	1,646	165	10	165		933	16
17	New Horizons-residents phones			2002	3,161	316	10	316		1,765	17
18	ABC-owners extras			2003	2,571	171	15	171		856	18
19	ABC-owners extras			2003	5,511	367	15	367		1,836	19
20	ABC [GT Mechanical]-Replace B1 compressor			2007	3,383	677	5	677		1,071	20
21	Mohawk-Calhoun Carpet Admin area			2007	2,747	92	5	92		92	21
22	ABC-New carpeting Nile Room			2007	6,053	504	5	504		504	22
23	ABC-New patio door operator			2007	4,046	169	10	169		169	23
24	GTMECH-Exhaust motor & wheel blade			2007	4,791	120	10	120		120	24
25	ABC-Removal & repair of hot water piping			2007	4,170	28	25	28		28	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 Des Plaines Rehab & HC

0042010

Report Period Beginning:

1/1/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,599,819	\$ 274,575		\$ 207,078	\$ (67,497)	\$ 1,573,787	1
2									2
3	Related Party-Forum Prof Center Building:								3
4	Leasehold Improvement-Remodeling	1980	11,034		15			11,034	4
5	Leasehold Improvement-Remodeling	1980	17,284		20			17,284	5
6	Leasehold Improvement-Tenant Improvement	1987	893		13			893	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,204	200	16	200		2,604	8
9	Leasehold Improvement-Build.Improv.	1996	1,130	71	16	71		843	9
10	Leasehold Improvement-Asphalting	2000	88		3			88	10
11	Leasehold Improvement-DAI	2001	154	15	10	15		95	11
12	Leasehold Improvement-Bathrooms	2002	667	73	7	73		391	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		819	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	2,050	391	7	391		1,213	14
15	Leasehold Improvement-sidewalks-City of Chic.	2007	106	21	5	21		21	15
16	Leasehold Improvement-Carpet: Superior Install.	2007	97	19	5	19		19	16
17	Leasehold Improvement-Condensing Unit: Suite 140	2007	841	168	5	168		168	17
18	Leasehold Improvement-Add-on Improvement, fixture base	1980	71		23			71	18
19	Leasehold Improvement-Add-on Improvement, lighting base	2001	123		5			123	19
20	Leasehold Improvements-fire extinguishers	2007	10	2	5	2		2	20
21									21
22									22
23									23
24	Related Party-AMS:								24
25	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	25
26	Leasehold Improvement-Remodeling	2002	4,861	694	7	694		3,386	26
27	Leasehold Improvement-Remodeling	2003	5,085	726	7	726		3,525	27
28									28
29									29
30	Forum Extended Care, LLC-building/building improv	1999			30				30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,669,432	\$ 277,120		\$ 209,623	\$ (67,497)	\$ 1,636,643	34

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

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 1/1/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 643,315	\$ 87,441	\$ 64,003	\$ (23,438)	Various	\$ 450,213	71
72	Current Year Purchases	23,172	1,246	1,246		Various	1,246	72
73	Fully Depreciated Assets	82,463	1,389	1,389		Various	82,463	73
74								74
75	TOTALS	\$ 748,950	\$ 90,076	\$ 66,638	\$ (23,438)		\$ 533,922	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus	2001	2001	\$ 49,826	\$	\$	\$	5	\$ 49,826	76
77										77
78										78
79	Related Party-AMS	Lumina/Chev/2004	2004	117	29	29		3	117	79
80	TOTALS			\$ 49,943	\$ 29	\$ 29	\$		\$ 49,943	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,484,371	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 367,225	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 276,290	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (90,935)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,220,508	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning 7/1/2001

Ending 7/1/2008

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

Fiscal Year Ending Annual Rent

12.	<u>/2008</u>	\$ <u>835k</u>
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</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: \$ 8,167 Description: Copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related party - AMS</u>		\$ <u>#####</u>	\$ <u>19,580</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>19,580</u>	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled Nursing on site</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 518,890	\$		\$ 518,890	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			46,156			46,156	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			923,774			923,774	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 prescripts				421,544		421,544	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1, 39-3, if any								12
13	Other (specify): See Pg 16A					64,971	388,937		453,908	13
14	TOTAL			\$		\$ 1,553,791	\$ 810,481		\$ 2,364,272	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Page 16
Col 5: PT,OT, & ST
Col 6: Supplies

XIV. Special Services (Direct Cost)

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	Col. No.
1. OT	39-3	To Col 5	\$518,890.42
2. ST	39-3	To Col 5	46,155.58
3.			
4. PT	39-3	To Col 5	923,773.70
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			421,543.65
Manual Input from Related Party- Forum Drugs			
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	421,543.65
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	64,971.00
Other			558,752.87
Manual Input: Related Party - Pyramid			(45,490.00)
Manual Input: Related Party FEClI - I.V.			(124,326.00)
13. Col 6: Supplies Total		To Col 6	388,936.87
13. Total Line 13, Column 8			388,936.87
14. Total			2,364,271.22

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 1/1/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$	\$ 267	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>85,000</u>)	1,381,108	1,381,108	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		57,363	6
7	Other Prepaid Expenses	6,359	6,359	7
8	Accounts Receivable (owners or related parties)	2,669,584	4,187,289	8
9	Other(specify): <u>Due from 3rd parties</u>	11,183	148,079	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,068,234	\$ 5,780,465	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		16,591	11
12	Long-Term Investments			12
13	Land		1,003,985	13
14	Buildings, at Historical Cost		9,685,956	14
15	Leasehold Improvements, at Historical Cost	600,386	617,179	15
16	Equipment, at Historical Cost	277,614	1,353,092	16
17	Accumulated Depreciation (book methods)	(388,183)	(2,683,922)	17
18	Deferred Charges	69,873	69,873	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		740,023	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Refinancing Fee</u>		204,557	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 559,690	\$ 11,007,334	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,627,924	\$ 16,787,799	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 722,449	\$ 729,209	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	149,214	149,214	28
29	Short-Term Notes Payable	1,418,797	1,531,741	29
30	Accrued Salaries Payable	380,576	380,576	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,595	24,595	31
32	Accrued Real Estate Taxes(Sch.IX-B)		353,000	32
33	Accrued Interest Payable	5,710	58,539	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	189,881	189,881	35
	Other Current Liabilities(specify):			
36	<u>Accrued exp, ins.sales tax, etc</u>	16,945	16,945	36
37	<u>Deferred Revenue</u>		444,608	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,908,167	\$ 3,878,308	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,604,525	39
40	Mortgage Payable		10,112,545	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Related Party-Note Payable</u>	1,326,940		43
44	<u>Shareholder Loans</u>	167,000	167,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,493,940	\$ 11,884,070	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,402,107	\$ 15,762,378	46
47	TOTAL EQUITY(page 18, line 24)	\$ 225,817	\$ 1,025,421	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,627,924	\$ 16,787,799	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 45,641	1
2	Restatements (describe):		2
3	External audit adj	4,575	3
4	Income tax adjustment	(200,000)	4
5	Rent Adjustment	(50,000)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (199,784)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	425,601	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)	\$ 425,601	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)	\$ 225,817	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 1/1/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,011,808	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,011,808	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	31,970	6
7	Oxygen	5,769	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 37,739	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	49	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	18,247	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,298	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,594	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,452	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,452	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income & Gain on Sale of Assets	4,046	28
28a	Adj to Prior Yr Expense	24,589	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,635	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,113,228	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,371,170	31
32	Health Care	2,602,085	32
33	General Administration	2,142,508	33
B. Capital Expense			
34	Ownership	1,790,250	34
C. Ancillary Expense			
35	Special Cost Centers	2,469,117	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,435,355	40
41	Income before Income Taxes (line 30 minus line 40)**	677,873	41
42	Income Taxes	(252,272)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 425,601	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 Des Plaines Rehab & HC

0042010

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing				1	
2	Assistant Director of Nursing	1,881	1,993	73,800	37.03	2
3	Registered Nurses	29,649	31,412	974,248	31.02	3
4	Licensed Practical Nurses	9,707	10,195	254,900	25.00	4
5	CNAs & Orderlies	53,517	56,560	780,400	13.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,467	2,639	45,268	17.15	8
9	Activity Director	928	1,040	22,755	21.88	9
10	Activity Assistants	5,922	6,343	64,674	10.20	10
11	Social Service Workers	1,888	2,072	40,541	19.57	11
12	Dietician					12
13	Food Service Supervisor	1,296	1,320	27,692	20.98	13
14	Head Cook	2,228	2,480	39,876	16.08	14
15	Cook Helpers/Assistants	36,006	38,761	406,784	10.49	15
16	Dishwashers					16
17	Maintenance Workers	1,992	2,042	44,302	21.70	17
18	Housekeepers	14,725	15,692	161,862	10.31	18
19	Laundry	2,482	2,673	26,470	9.90	19
20	Administrator	1,864	2,000	69,057	34.53	20
21	Assistant Administrator					21
22	Other Administrative	6,214	7,036	214,957	30.55	22
23	Office Manager	1,960	2,048	31,355	15.31	23
24	Clerical	2,798	2,830	23,634	8.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,986	2,146	67,212	31.32	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	277	277	2,462	8.89	31
32	Other Health Care Unit Director	1,904	2,080	33,377	16.05	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,691	193,639	\$ 3,405,626 *	\$ 17.59	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	Monthly	\$ 8,823	1-3	35
36	Medical Director	Monthly	60,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,640	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				44
45	Social Service Consultant	9	756	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	\$ 72,219		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

Alden Des Plaines Rehab & HC
Legal Fee Support
2007

Pg 21A

Legal Fees Reported on Pg 21, Section C:	20,771.00
Less: Collection, estates & other non-allowable legal fees listed on Pg 5, Ln 19	(15,754.00)
Less: Non-allowable legal fees, if any, deducted on Pg 5A	<hr/>
Allowable Legal Fees	<u><u>5,017.00</u></u>

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 1/1/07

Ending: 12/31/07

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 Assoc. \$4292
- (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. \$ 17,925 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. \$ 60,225
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. \$ 19,639 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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? _____ 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 \$5,000, 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.