

		FOR BHF USE					

LL1

**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:** 0046524

**Facility Name:** ALDEN ESTATES OF BARRINGTON

**Address:** 1420 SOUTH BARRINGTON ROAD BARRINGTON 60010  
 Number City Zip Code

**County:** COOK

**Telephone Number:** (847) 382-6664 **Fax #** (847)382-6395

**HFS ID Number:** 77-06106669

**Date of Initial License for Current Owners:** 12/01/03

**Type of Ownership:**

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

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 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.

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

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON

# 0046524 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	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,086	3,193	14,852	25,131	8
9	SNF/PED					9
10	ICF	11,137	3,466	0	14,603	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,223	6,659	14,852	39,734	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.57%

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)

n/a

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 12/01/03

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

YES  Date 12/1/03 NO

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

YES  NO  If YES, enter number of beds certified 150 and days of care provided 13,689

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 ESTATES OF BARRINGTON # 0046524 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	
	<b>A. General Services</b>											
1	Dietary	632,143	77,537	12,000	721,680	1,824	723,504	1,139	724,643			1
2	Food Purchase		398,798		398,798	(39,440)	359,358	(94,016)	265,342			2
3	Housekeeping	153,435	44,949		198,384	1,438	199,822	3,215	203,037			3
4	Laundry	56,907	15,542	1,028	73,477	337	73,814		73,814			4
5	Heat and Other Utilities			227,397	227,397		227,397	3,197	230,594			5
6	Maintenance	43,869		255,336	299,205	207	299,412	34,508	333,920			6
7	Other (specify):* Security/Related Party			181	181		181	7,041	7,222			7
8	<b>TOTAL General Services</b>	<b>886,354</b>	<b>536,826</b>	<b>495,942</b>	<b>1,919,122</b>	<b>(35,634)</b>	<b>1,883,488</b>	<b>(44,916)</b>	<b>1,838,572</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			38,512	38,512		38,512		38,512			9
10	Nursing and Medical Records	2,211,681	413,103	4,546	2,629,330	(154,569)	2,474,761	36,178	2,510,939			10
10a	Therapy	12,709			12,709		12,709		12,709			10a
11	Activities	72,082	6,031	10,683	88,796	175	88,971		88,971			11
12	Social Services	33,158			33,158		33,158		33,158			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related Party							6,799	6,799			15
16	<b>TOTAL Health Care and Programs</b>	<b>2,329,630</b>	<b>419,134</b>	<b>53,741</b>	<b>2,802,505</b>	<b>(154,394)</b>	<b>2,648,111</b>	<b>42,977</b>	<b>2,691,088</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	124,579			124,579		124,579	80,340	204,919			17
18	Directors Fees											18
19	Professional Services			667,950	667,950		667,950	(575,683)	92,267			19
20	Dues, Fees, Subscriptions & Promotions			106,494	106,494		106,494	(89,658)	16,836			20
21	Clerical & General Office Expenses	213,842	39,645	113,099	366,586	880	367,466	134,968	502,434			21
22	Employee Benefits & Payroll Taxes			697,107	697,107	26,981	724,088	(20,965)	703,123			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,957	6,957		6,957	1,765	8,722			24
25	Other Admin. Staff Transportation			13,679	13,679		13,679	9,615	23,294			25
26	Insurance-Prop.Liab.Malpractice			145,232	145,232	(681)	144,551	15,119	159,670			26
27	Other (specify):* Related Party			(36,498)	(36,498)		(36,498)	85,628	49,130			27
28	<b>TOTAL General Administration</b>	<b>338,421</b>	<b>39,645</b>	<b>1,714,020</b>	<b>2,092,086</b>	<b>27,180</b>	<b>2,119,266</b>	<b>(358,871)</b>	<b>1,760,395</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,554,405</b>	<b>995,605</b>	<b>2,263,703</b>	<b>6,813,713</b>	<b>(162,848)</b>	<b>6,650,865</b>	<b>(360,810)</b>	<b>6,290,055</b>			<b>29</b>

\*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 ESTATES OF BARRINGTON #0046524 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
	<b>D. Ownership</b>										
30	Depreciation			49,629	49,629		49,629	401,719	451,348		30
31	Amortization of Pre-Op. & Org.							10,077	10,077		31
32	Interest			69,866	69,866	681	70,547	804,454	875,001		32
33	Real Estate Taxes							385,408	385,408		33
34	Rent-Facility & Grounds			1,550,596	1,550,596		1,550,596	(1,550,596)			34
35	Rent-Equipment & Vehicles			18,799	18,799		18,799	29,071	47,870		35
36	Other (specify):* MIP							83,072	83,072		36
37	<b>TOTAL Ownership</b>			1,688,890	1,688,890	681	1,689,571	163,206	1,852,777		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	524,230	976,789	1,491,815	2,992,834	162,167	3,155,001	(176,995)	2,978,006		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			82,125	82,125		82,125		82,125		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>	524,230	976,789	1,573,940	3,074,959	162,167	3,237,126	(176,995)	3,060,131		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,078,635	1,972,394	5,526,533	11,577,562		11,577,562	(374,599)	11,202,963		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		(39,440.00)	Employee Meals
	22	39,440.00	
10		(162,167.00)	Oxygen Costs
	39	162,167.00	
26		(681.00)	Insurance Expense
	32	681.00	
22		(12,459.23)	Employee Uniforms
	1	1,823.57	
	3	1,437.97	
	4	336.90	
	6	207.07	
	10	7,598.37	
	11	175.56	
	21	879.79	
		<hr/>	
		(0.00)	

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

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	(608)	2		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	(10,856)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,300)	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	(19,971)	21		17
18	Fines and Penalties	(33)	32		18
19	Entertainment	(2,405)	20		19
20	Contributions	(7,484)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,357)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	36,498	27		24
25	Fund Raising, Advertising and Promotional	(35,531)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,524)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (56,571)		\$	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)	(117,260)	Various	34
35	Other- Attach Schedule	(200,768)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (318,028)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (374,599)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## ALDEN ESTATES OF BARRINGTON

ID# 0046524

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late fees on utilities	\$ 915	5	1
2	Intercompany Interest	(69,833)	32	2
3	Marketing Manager & Aides ( 6701-100-009)	(120,221)	21	3
4	Misc. Income (Med records)	(5,048)	10	4
5	Misc. Income ( Vending machine)	(1,057)	2	5
6	Misc. Income ( Food Rebate)	(458)	2	6
7	Employee Benefits for Marketing manager	(20,548)	22	7
8	Back out 29.31% of PAC fees frm standard IHCA bills	(2,427)	20	8
9	Vendor Settlement - Chemcraft Industries, Inc.	(232)	21	9
10	Vendor Settlement - Chemcraft Industries, Inc.	232	6	10
11	Backout Bank Charges - Barrington, LLC	196	21	11
12	Backout fines & penalties on Barrington, LLC	(5,712)	32	12
13				13
14				14
15	Reduce deprec exp on Pg 12 items < \$2,500 - Barrington	(2,064)	30	15
16	Reduce deprec exp on pg 12 items <\$2,500 - Barr, LLC	(154)	30	16
17				17
18				18
19	Expense capital items >\$2,500 on Pg 12 - Barrington	13,442	6	19
20	Expense capital items >\$2,500 on Pg 12 - Barr, LLC	2,636	6	20
21	Depreciation adj \$2,500 on pg 13	(3,548)	30	21
22	Depreciation adj \$2,500 on pg 13	17,467	6	22
23	Add back prior year 2003 tax refund	12,475	33	23
24				24
25	Eliminated Deprec Expense on LLC's building	(16,168)	30	25
26	Adj Depreciation Expense to detail	244	30	26
27	Deming Leadership Related Party Adjustment	77	24	27
28	Eliminate PAC dinner	(150)	24	28
29	Eliminate non-care employee benefits	(417)	22	29
30	Eliminate non-care marketing costs	(417)	20	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(200,768)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	4,610	(3,471)	0	0	0	0	0	0	0	1,139	1
2	Food Purchase	(4,422)	0	0	(89,594)	0	0	0	0	0	0	0	(94,016)	2
3	Housekeeping	0	0	3,215	0	0	0	0	0	0	0	0	3,215	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	915	0	2,282	0	0	0	0	0	0	0	0	3,197	5
6	Maintenance	33,777	0	2,097	0	0	0	(1,366)	0	0	0	0	34,508	6
7	Other (specify):*	0	0	5,159	1,882	0	0	0	0	0	0	0	7,041	7
8	<b>TOTAL General Services</b>	<b>30,270</b>	<b>0</b>	<b>17,363</b>	<b>(91,183)</b>	<b>0</b>	<b>0</b>	<b>(1,366)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(44,916)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(5,048)	0	38,947	1,707	572	0	0	0	0	0	0	36,178	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	6,799	0	0	0	0	0	0	0	0	6,799	15
16	<b>TOTAL Health Care and Programs</b>	<b>(5,048)</b>	<b>0</b>	<b>45,746</b>	<b>1,707</b>	<b>572</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>42,977</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	80,340	0	0	0	0	0	0	0	0	80,340	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,357)	25,429	(589,755)	0	0	0	0	0	0	0	0	(575,683)	19
20	Fees, Subscriptions & Promotions	(50,788)	250	(39,120)	0	0	0	0	0	0	0	0	(89,658)	20
21	Clerical & General Office Expenses	(140,228)	368	193,262	41,913	39,653	0	0	0	0	0	0	134,968	21
22	Employee Benefits & Payroll Taxes	(20,965)	0	0	0	0	0	0	0	0	0	0	(20,965)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(73)	0	1,838	0	0	0	0	0	0	0	0	1,765	24
25	Other Admin. Staff Transportation	0	0	9,615	0	0	0	0	0	0	0	0	9,615	25
26	Insurance-Prop.Liab.Malpractice	0	14,950	169	0	0	0	0	0	0	0	0	15,119	26
27	Other (specify):*	36,498	0	42,813	3,914	2,403	0	0	0	0	0	0	85,628	27
28	<b>TOTAL General Administration</b>	<b>(186,913)</b>	<b>40,997</b>	<b>(300,838)</b>	<b>45,827</b>	<b>42,056</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(358,871)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(161,691)</b>	<b>40,997</b>	<b>(237,729)</b>	<b>(43,649)</b>	<b>42,628</b>	<b>0</b>	<b>(1,366)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(360,810)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

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	(21,690)	418,656	3,226	0	1,527	0	0	0	0	0	0	401,719	30
31	Amortization of Pre-Op. & Org.	0	10,025	52	0	0	0	0	0	0	0	0	10,077	31
32	Interest	(86,434)	785,932	102,246	0	2,255	455	0	0	0	0	0	804,454	32
33	Real Estate Taxes	12,475	368,682	3,518	0	733	0	0	0	0	0	0	385,408	33
34	Rent-Facility & Grounds	0	(1,550,596)	0	0	0	0	0	0	0	0	0	(1,550,596)	34
35	Rent-Equipment & Vehicles	0	0	29,071	0	0	0	0	0	0	0	0	29,071	35
36	Other (specify):*	0	83,072	0	0	0	0	0	0	0	0	0	83,072	36
37	<b>TOTAL Ownership</b>	<b>(95,648)</b>	<b>115,771</b>	<b>138,113</b>	<b>0</b>	<b>4,515</b>	<b>455</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>163,206</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(75,876)	(72,075)	(29,044)	0	0	0	0	0	(176,995)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(75,876)</b>	<b>(72,075)</b>	<b>(29,044)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(176,995)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(257,339)</b>	<b>156,768</b>	<b>(99,616)</b>	<b>(119,525)</b>	<b>(24,932)</b>	<b>(28,589)</b>	<b>(1,366)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(374,599)</b>	<b>45</b>

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

Report Period Beginning:

1/1/07

Ending:

12/31/07

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group, Ltd	100%	See Pg 6K		See Pg 6K		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,550,596	Alden Barrington, LLC		\$	\$ (1,550,596)	1
2	V	19 Legal Fees - Non Collections		Alden Barrington, LLC	100.00%	17,667	17,667	2
3	V	19 Professional fees		Alden Barrington, LLC	100.00%	7,762	7,762	3
4	V	21 Bank charges		Alden Barrington, LLC	100.00%	196	196	4
5	V	20 Dues & Subscription		Alden Barrington, LLC	100.00%	250	250	5
6	V	21 Freight/Mover Service		Alden Barrington, LLC	100.00%	172	172	6
7	V	32 Fines & Penalties		Alden Barrington, LLC	100.00%	5,712	5,712	7
8	V	33 Real Estates Tax Expense		Alden Barrington, LLC	100.00%	368,682	368,682	8
9	V	26 General Insurance Expense		Alden Barrington, LLC	100.00%	14,950	14,950	9
10	V	36 Mortgage Insurance Premium		Alden Barrington, LLC	100.00%	83,072	83,072	10
11	V	32 Interest - Mortgage & other		Alden Barrington, LLC	100.00%	780,220	780,220	11
12	V	30 Depreciation Expense		Alden Barrington, LLC	100.00%	418,656	418,656	12
13	V	31 Amortization		Alden Barrington, LLC	100.00%	10,025	10,025	13
14	Total		\$ 1,550,596			\$ 1,707,364	\$ * 156,768	14

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON# 0046524Report 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	\$ 624,519	Alden Management Services, Inc.	0.00%	\$ 34,764	\$ (589,755)	15
16	V	21 Genl&Admin		Alden Management Services, Inc.		193,262	193,262	16
17	V	5 Utilities		Alden Management Services, Inc.		2,282	2,282	17
18	V	6 Repair & Maint	27,334	Alden Management Services, Inc.		29,431	2,097	18
19	V	24 Travel & Seminar		Alden Management Services, Inc.		1,838	1,838	19
20	V	25 Other Admin Travel		Alden Management Services, Inc.		9,615	9,615	20
21	V	26 Forum Allocated Insurance		Alden Management Services, Inc.		169	169	21
22	V	20 Dues, Subscriptions	39,510	Alden Management Services, Inc.		390	(39,120)	22
23	V	30 Depreciation		Alden Management Services, Inc.		3,226	3,226	23
24	V	31 Amortization		Alden Management Services, Inc.		52	52	24
25	V	33 Real Estate Taxes		Alden Management Services, Inc.		3,518	3,518	25
26	V	35 Rent Equip & Vehic		Alden Management Services, Inc.		29,071	29,071	26
27	V	32 Interest		Alden Management Services, Inc.		102,246	102,246	27
28	V	7 Genl Serv Salary		Alden Management Services, Inc.		5,159	5,159	28
29	V	15 Health Care Salary		Alden Management Services, Inc.		6,799	6,799	29
30	V	27 G & A Salaries		Alden Management Services, Inc.		42,813	42,813	30
31	V	1 Dietary Aide Salary		Alden Management Services, Inc.		4,610	4,610	31
32	V	3 Housekeeping salary		Alden Management Services, Inc.		3,215	3,215	32
33	V	10 Nurs & Med Records salary		Alden Management Services, Inc.		38,947	38,947	33
34	V	17 Administrative salary		Alden Management Services, Inc.		80,340	80,340	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 691,363			\$ 591,747	\$ * (99,616)	39

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON# 0046524Report 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	1	Diet Consultant	\$ 12,000	Prism Health Care Services, Inc.	0.00%	\$ 4,124	\$ (7,876)	15
16	V	1	Dietary salary		Prism Health Care Services, Inc.		4,405	4,405	16
17	V	2	Tube Feeding	148,728	Prism Health Care Services, Inc.		59,134	(89,594)	17
18	V	10	Equipment Rental	3,060	Prism Health Care Services, Inc.		4,767	1,707	18
19	V	39	Supplies	221,668	Prism Health Care Services, Inc.		117,095	(104,573)	19
20	V	39	Vent Rental		Prism Health Care Services, Inc.		28,697	28,697	20
21	V	21	Salary G & A		Prism Health Care Services, Inc.		16,679	16,679	21
22	V	27	Employee Benefit		Prism Health Care Services, Inc.		3,914	3,914	22
23	V	7	Employee Benefit		Prism Health Care Services, Inc.		1,882	1,882	23
24	V	21	G & A				25,234	25,234	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		\$ 385,456				\$ 265,931	\$ * (119,525)	39

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON# 0046524Report 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	39	Drugs	\$ 323,515	Forum Extended Care Services II, Inc.	0.00%	\$ 479,844	\$ 156,329	15
16	V	39	I.V. Drugs	255,519	Forum Extended Care Services II, Inc.		28,034	(227,485)	16
17	V	39	Wound care	4,466	Forum Extended Care Services II, Inc.		3,547	(919)	17
18	V	10	House stock	13,898	Forum Extended Care Services II, Inc.		13,264	(634)	18
19	V	10	Pharmacy Consultant	3,500	Forum Extended Care Services II, Inc.		4,706	1,206	19
20	V	27	Employee Vaccination	1,853	Forum Extended Care Services II, Inc.		1,453	(400)	20
21	V	27	Employee Benefit - G & A		Forum Extended Care Services II, Inc.		2,803	2,803	21
22	V	21	Salary G & A		Forum Extended Care Services II, Inc.		21,274	21,274	22
23	V	21	General Administration		Forum Extended Care Services II, Inc.		18,379	18,379	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		2,255	2,255	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		733	733	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		\$ 602,751				\$ 577,819	\$ * (24,932)	39

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON# 0046524Report 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	39	Therapy	\$ 1,451,935	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,422,891	\$ (29,044)	15
16	V	32	Interest		Community Physical Therapy & Associates, Ltd.		455	455	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			\$ 1,451,935			\$ 1,423,346	\$ * (28,589)	39

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

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	6 Repairs & Maintenance	\$ 100,302	Alden Bennett Construction Company, Inc.	0.00%	\$ 98,936	\$ (1,366)	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		\$ 100,302			\$ 98,936	\$ *	(1,366) 39

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

STATE OF ILLINIOS

Facility Name & ID Number

ALDEN ESTATES OF BARRINGTON, INC.

Provider No.

46524

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			

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON # 0046524 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 A. Schlossberg	President	CEO	100.00	165,116	1.376	0.03	Salary	\$ 5,884	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	62,261	1.376	0.03	Salary	2,219	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	36,654	1.376	0.03	Salary	1,306	6-7	3
4											4
5											5
6	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										7
8	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.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,409		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 ESTATES OF BARRINGTON

# 0046524

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

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

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

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	\$ 39,734	\$ 2,282	1
2	24	Travel & Seminar	Patient Days	1,154,703	29	53,403	39,734	1,838	2
3	25	Other Admin Travel	Patient Days	1,154,703	29	279,431	39,734	9,615	3
4	26	Insurance	Patient Days	1,154,703	29	4,925	39,734	169	4
5	20	Dues & Subscription	Patient Days	1,154,703	29	11,328	39,734	390	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	39,734	52	7
8	33	Real estates Tax	Patient Days	1,154,703	29	102,244	39,734	3,518	8
9	35	Rent - Equip & Vehicles	Patient Days	1,154,703	29	844,835	39,734	29,071	9
10	32	Interest	Patient Days	1,154,703	29	2,971,354	39,734	102,246	10
11	1	Dietary	Patient Days	1,154,703	29	133,965	133,965	4,610	11
12	3	Housekeeping	Patient Days	1,154,703	29	93,421	93,421	3,215	12
13	7	Employee benefits - Gen'l Srvc	Patient Days	1,154,703	29	149,914	39,734	5,159	13
14	10	Nurs & Med Records Salary	Patient Days	1,154,703	29	1,131,818	1,178,420	38,947	14
15	15	Employee benefits - Health care	Patient Days	1,154,703	29	197,574	39,734	6,799	15
16	17	Administrative Salary	Patient Days	1,154,703	29	2,334,744	1,946,420	80,340	16
17									17
18	27	Employee benefits - Admin	Patient Days	1,154,703	29	1,244,181	39,734	42,813	18
19	19	Professional Fees	Patient Days	1,154,703	29	1,010,272	531,592	34,764	19
20	21	Gen'l & Admin	Patient Days	1,154,703	29	5,616,348	4,942,836	193,262	20
21	6	Repair & Maintenance	Patient Days	1,154,703	29	855,298	666,770	29,431	21
22									22
23									23
24									24
25	TOTALS					\$ 17,196,438	\$ 9,493,424	\$ 591,747	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Cambridge		X	Mortgage		12/22/05	\$ 14,574,100	\$ 14,442,945	12/1/2046	5.7700	\$ 779,770	1								
2	AFCO (7053)		X	Working Capital							450	2								
3												3								
4												4								
5	Insurance Interest-see reclass		x	Malpractice Insurance							681	5								
<b>Working Capital</b>																				
6	Related Party - CPT		x	Working Capital							455	6								
7	Related Party - AMS		x	Working Capital							102,246	7								
8	Related Party - FECII		x	Working Capital							2,255	8								
9	<b>TOTAL Facility Related</b>						\$ 14,574,100	\$ 14,442,945			\$ 885,857	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income Repl Reserve											10								
11	Int Income on others (GL4646 & 4975)										(10,856)	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (10,856)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 14,574,100	\$ 14,442,945			\$ 875,001	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 83,072 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 ESTATES OF BARRINGTON COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0046524

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>3,518.00</u>
2. <u>See Attached (12 Pg Supplement)</u>	<u>Related Party-Forum Professional Cen</u>	\$ <u>37,806.00</u>	\$ <u>733.00</u>
3. <u>01-12-107-106-0000</u>	<u>Building</u>	\$ <u>370,057.00</u>	\$ <u>370,057.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>649,262.00</u>	\$ <u>374,308.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 ESTATES OF BARRINGTON

# 0046524 Report Period Beginning:

1/1/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 59,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>150 Bed Facility</u>		<u>2003</u>	<u>\$ 1,206,945</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 1,206,945</b>	3

Facility Name &amp; ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

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	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Building Acquisition: GL 1702/LLC		2003	6,933,811	177,790	39	177,790		725,974	4
5	Renovation: interior: GL 1703/LLC		2007	4,351,504	83,683	39	83,683		83,683	5
6	Adj Value For D/T prior owners (LLC)		2003	204,498	5,244		5,244		21,411	6
7										7
8	Related Party-Forum		1978	14,541		25			14,541	8
	Improvement Type**									
9	ABC-Water Heater GL 1705/Inc.		2004	32,509	2,167	10	2,167		7,405	9
10	Oak Fire and Security-Fire alarm control panel GL 1705/Inc.		2004	6,400	427	10	427		1,387	10
11	Oak Fire and Security-Air handler shutdown GL 1705/Inc.		2004	3,120	208	10	208		676	11
12	ABC-37 gallon water heater GL 1705/Inc.		2004	7,274	727	12	727		2,425	12
13	Top Notch: Compressor: Kitchen GL 1705/Inc.		2004	1,603	160	10	160		495	13
14	Polina Landscape(sod, soil and clay) GL 1704/Inc.		2004	7,388	2,052	12	2,052		7,388	14
15	Central Sprinklers Auto-repair sprinkler system: GL 1705/Inc.		2005	13,721	1,372	10	1,372		4,116	15
16	CSAS-replace dry spinkler: GL 1705/Inc.		2005	3,495	349	10	349		990	16
17	CSAS-replace dry spinkler: GL 1705/Inc.		2005	1,843	184	10	184		507	17
18	GT Mechanical-replace fans: GL 1705/Inc.		2005	1,681	168	10	168		476	18
19	Top Notch-dishwasher(pump/impe GL 1705/Inc.		2005	4,490	449	10	449		973	19
20	ABC Repair damaged sewer line: GL 1705/Inc.		2005	11,445	1,144	10	1,144		2,384	20
21						10				21
22	Projector Screen Installation: GL 1705/Inc.		2006	3,674	734	5	734		1,225	22
23	Replace blower wheel/air handler: GL 1705/Inc.		2006	4,189	419	10	419		559	23
24	Replace chiller controller: GL 1705/Inc.		2006	5,258	526	10	526		701	24
25	Install cable thru pipes in hallway to each wallplate:GL 1705/Inc.		2006	14,500	725	20	725		1,148	25
26	Replace boiler expansion tanks: GL 1705/Inc.		2006	4,607	230	20	230		345	26
27	New Roof: GL 1703/LLC		2006	138,536	13,854	10	13,854		14,119	27
28	ABC renovation/exterior/landscaping: GL 1703/LLC		2007	321,660	13,703	15	13,703		13,703	28
29	ABC-New doors/frames: GL 1703/Inc.		2007	11,096	416	15	416		416	29
30	ABC-New corner guards for new wall coverings: GL 1704/Inc.		2007	2,645	220	10	220		220	30
31	ABC-New plumbing in Parlor Room: Inc.		2007	20,504	1,709	20	1,709		1,709	31
32	New Fire Sprinkler: GL 1705/Inc.		2007	2,791	256	10	256		256	32
33	Replace fire sprinklers: GL 1705/Inc.		2007	2,887	265	10	265		265	33
34	American Backflow: repipe/repair backflow/drain/etc.: GL 1705/Inc.		2007	2,955	222	10	222		222	34
35	ABC-Installed new windows: GL 1705/Inc.		2007	3,847	256	15	256			35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

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	
37	Install new door & hollow metal hardward	2007	\$ 11,096	\$ 416	20	\$ 416	\$	\$ 416	37
38					10				38
39	ABC - repipe existing ansol system	2007	7,263	605	10	605	(0)	605	39
40									40
41									41
42	replaced plumbing for ice cream parlor	2007	20,504	1,709	10	1,709		1,709	42
43	install irigation	2007	2,955	222	10	222		222	43
44	replace new window	2007	3,847	256	10	256		256	44
45	install new electric for door & food tray line	2007	6,998	272	15	272		272	45
46	install new sprinkler heads	2007	5,063	295	10	295		295	46
47	installed new exhaust fan	2007	3,125	182	10	182		182	47
48	installed new landscaping	2007	18,391	920	10	920		920	48
49	installed new irrigation line & heads	2007	7,017	351	10	351		351	49
50	replaced new air compressor	2007	24,614	855	12	855		855	50
51	replaced drywall carpentry	2007	26,605	665	10	665		665	51
52	replaced broken door closer with new closer worn ceiling	2007	2,976	149	5	149		149	52
53	replaced broken kitchen equipment with new equipment	2007	9,282	77	10	77		77	53
54	relaced broken kitchen equipment with new equipment	2007	4,473	37	10	37		37	54
55									55
56	Renovation Exterior Landscaping ( LLC)	2007	7,938	44	15	44		44	56
57	Renovation Extras, change order ( LLC)	2007	1,100		15				57
58	Landscaping: Rocks,Floral, Edging (LLC)	2007	24,500	953	15	953		953	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,326,218	\$ 317,666		\$ 317,666	\$ (0)	\$ 917,726	70

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

Facility Name &amp; ID Number ALDEN ESTATES OF BARRINGTON

# 0046524

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 12,326,218	\$ 317,666		\$ 317,666	\$ (0)	\$ 917,726	1
2									2
3	<b>Related Party-Forum Prof Center Building:</b>								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	<b>Related Party-AMS:</b>								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	<b>Forum Extended Care, LLC-building/building improv</b>	1999	10,485	266	30	266		2,420	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,406,317	\$ 320,477		\$ 320,477	\$ (0)	\$ 983,002	34

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON # 0046524 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	\$ 1,494,501	\$ 123,127	\$ 123,127	\$	various	\$ 255,488	71
72	Current Year Purchases	102,683	7,444	7,444		various	7,444	72
73	Fully Depreciated Assets	70,932	271	271		various	70,932	73
74								74
75	TOTALS	\$ 1,668,116	\$ 130,842	\$ 130,842	\$		\$ 333,864	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Related Party-AMS	Lumina/Chev/2004	2004	117	29	29		3	117	79
80	TOTALS			\$ 117	\$ 29	\$ 29	\$		\$ 117	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)	\$ 15,281,495	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 451,348	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 451,348	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,316,984	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 back out

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning 12/31/03

Ending 11/20/08

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2008</u>	\$ <u>varies</u>
13.	<u>12/31/2009</u>	\$ <u>varies</u>
14.	<u>12/31/2010</u>	\$ <u>varies</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 6,457 Description: Copy Machine Lease & Postage

(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>Auto - Business</u>		\$ <u>#####</u>	\$ <u>12,343</u>	17
18					18
19	<u>Related party-AMS</u>	<u>Various</u>	\$ <u>#####</u>	\$ <u>16,560</u>	19
20					20
21	<b>TOTAL</b>		\$ <u>#####</u>	\$ <u>28,903</u>	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 371,571	\$		\$ 371,571	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			101,765			101,765	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			570,325			570,325	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				479,844		479,844	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		57,542		44,814	119,241		221,597	12
13	Other (specify): See Pg 16A			466,688		334,416	431,800		1,232,904	13
14	<b>TOTAL</b>			\$ 524,230		\$ 1,422,891	\$ 1,030,885		\$ 2,978,006	14

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

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

XIV. Special Services (Direct Cost)

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	\$371,570.57
2. ST	39-3	To Col 5	101,764.79
3.			
4. PT	39-3	To Col 5	570,325.02
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			323,514.94
Manual Input from Related Party- Forum Drugs			156,329.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	----- 479,843.94 -----
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	57,542.00
12. Exceptional Care-Salaries:	See pg 16A	To Col. 5	44,814.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	119,240.80
Total Exceptional Care (Line 12, Col 8)			----- 221,596.80 -----
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	(29,044.00)
13. Col 5: Manual Input: Related Party - CPT		To Col 5	363,460.41
			----- 334,416.41 -----
13 Col 3. Salary Split			466,688.00
Other			982,187.70
Manual Input: Related Party - Prism			(75,877.00)
Manual Input: Related Party FECII - I.V.			(227,485.27)
Manual Input: Related Party FECII - Wound Care			(918.00)
Oxygen, from reclass worksheet			162,167.00
Reclasses to Column 5 for Lines 12 & b 13			(408,275.00)
13. Col 6: Supplies Total		To Col 6	----- 431,799.43 -----
13. Total Line 13, Column 8			----- 1,232,903.84 -----
14. Total			----- 2,978,004.96 =====

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON# 0046524Report 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 9,153	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>117,000</u> )	1,980,063	1,980,063	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		10,577	6
7	Other Prepaid Expenses	7,655	16,986	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From 3rd Parties</u>	29,416	29,416	9
	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,017,134	\$ 2,046,196	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,231,445	13
14	Buildings, at Historical Cost		11,959,027	14
15	Leasehold Improvements, at Historical Cost	309,868	1,576,170	15
16	Equipment, at Historical Cost	278,692	350,182	16
17	Accumulated Depreciation (book methods)	(109,024)	(1,163,342)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		437,443	19
	Accumulated Amortization - Organization & Pre-Operating Costs		(10,025)	20
21	Restricted Funds		89,000	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 479,536	\$ 14,469,900	24
	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,496,670	\$ 16,516,096	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 912,511	\$ 967,226	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	127,236	127,236	28
29	Short-Term Notes Payable		70,778	29
30	Accrued Salaries Payable	426,003	426,003	30
	Accrued Taxes Payable (excluding real estate taxes)	31,849	31,849	31
32	Accrued Real Estate Taxes(Sch.IX-B)		571,592	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Acc ins, exps, idpa, sales tax</u>	404,712	410,423	36
37				37
	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,902,311	\$ 2,605,107	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,442,945	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Dues to Affiliates</u>	2,137,488	1,762,789	43
44				44
	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,137,488	\$ 16,205,734	45
	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,039,799	\$ 18,810,842	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,543,129)	\$ (2,294,746)	47
	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,496,670	\$ 16,516,096	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,374,261)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding difference</b>	<b>(4)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,374,265)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(168,864)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(168,864)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,543,129)</b>	<b>24</b> *

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

Facility Name & ID Number ALDEN ESTATES OF BARRINGTON# 0046524Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$	1
2	Discounts and Allowances for all Levels	11,038,086	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,038,086	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,356	6
7	Oxygen	173,003	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 257,359	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	261	12
13	Barber and Beauty Care	1,282	13
14	Non-Patient Meals	608	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	16,328	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	123	19
20	Radiology and X-Ray	550	20
21	Other Medical Services	51,478	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 70,630	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	10,856	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,856	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Medical Records/Vending Maching/Food Rebate	6,563	28
28a	Adjustment to prior year expense	25,204	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 31,767	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,408,698	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,919,122	31
32	Health Care	2,802,505	32
33	General Administration	2,092,086	33
<b>B. Capital Expense</b>			
34	Ownership	1,688,890	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,992,834	35
36	Provider Participation Fee	82,125	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,577,562	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(168,864)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (168,864)	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 ESTATES OF BARRINGTON

# 0046524

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	1,718	1,718	\$ 71,542	\$ 41.64	1
2	Assistant Director of Nursing	240	240	9,808	40.87	2
3	Registered Nurses	35,884	38,080	1,183,044	31.07	3
4	Licensed Practical Nurses	13,657	14,609	392,570	26.87	4
5	CNAs & Orderlies	64,829	69,230	938,077	13.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,120	2,128	32,974	15.50	9
10	Activity Assistants	3,955	4,017	39,108	9.74	10
11	Social Service Workers	1,856	1,856	33,158	17.87	11
12	Dietician					12
13	Food Service Supervisor	3,510	3,510	97,470	27.77	13
14	Head Cook	4,455	4,569	98,091	21.47	14
15	Cook Helpers/Assistants	37,098	38,852	436,581	11.24	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	43,869	21.09	17
18	Housekeepers	14,641	15,603	153,435	9.83	18
19	Laundry	5,404	5,808	56,907	9.80	19
20	Administrator	838	838	26,047	31.08	20
21	Assistant Administrator	3,008	3,016	98,532	32.67	21
22	Other Administrative	6,532	6,686	179,660	26.87	22
23	Office Manager	1,525	1,525	22,338	14.65	23
24	Clerical	2,872	2,970	24,554	8.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,472	2,472	77,609	31.40	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,488	1,488	19,425	13.05	31
32	Other Health Care Unit Director	3,084	3,177	43,836	13.80	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	213,266	224,472	\$ 4,078,635 *	\$ 18.17	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	\$ 12,000	1-3	35
36	Medical Director	Monthly	38,512	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,880	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	Varies	1,573	11-3	44
45	Social Service Consultant	Varies	512	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,477		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 ESTATES OF BARRINGTON

# 0046524

Report Period Beginning: 1/1/07

Ending: 12/31/07

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debra Tumalek	Administrator	0	\$ 3,607	Workers' Compensation Insurance	\$ 98,101	IDPH License Fee	\$	
Lisa Ulbert	Administrator	0	4,797	Unemployment Compensation Insurance	94,108	Advertising: Employee Recruitment	5,820	
Patrica Cornelius	Administrator	0	27,442	FICA Taxes	302,724	Health Care Worker Background Check	1,540	
Fortis Evangelia	Assist. Administrator	0	65,905	Employee Health Insurance	85,728	(Indicate # of checks performed <u>154</u> )		
Mahlman Maryann	Assist. Administrator	0	14,055	Employee Meals	39,440	Patient Background Checks <u>315</u>	3,150	
Lesley Maria White	Assist. Administrator	0	7,602	Illinois Municipal Retirement Fund (IMRF)*		Related Party	390	
Pettinati Michael	Assist. Administrator	0	1,171	Union,Health, Welfare	64,074	Surety Bond	500	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	23,694	II Health Care Assoc (less Pac portion)	5,853	
(List each licensed administrator separately.)			\$ 124,579	dental & life insur	796	Eliminate non-care costs	(417)	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount	miscell empl costs/Employee Relations			Less: Public Relations Expense ( )	
			\$	vaccinations/drug tests/401K/Tuition Reimb			Non-allowable advertising ( )	
				Marketing Employ.Benefit deduction			Yellow page advertising ( )	
				Eliminate non-care costs				
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount		Line #	Amount	Amount	
AMS	Management Fees		\$ 624,519			\$	Out-of-State Travel	
BDO Seidman/Reznick	Accounting Fees		6,932				\$	
Ken Fisch	Legal Fees - Collection		11,357					
Barry Greenburg/Ken Fisch	Legal Fees - Non Collections		18,633					
Ungaretti	Legal Fees - Non Collections		2,690				In-State Travel	
Lawrence & Ken	Legal Fees - Non Collections		2,326				Related Party - AMS	
SMS	Billing Consultants		899				1,838	
Related Party - AMS	Consulting Services		316					
Medi.com	Billing Consultants		278				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 667,950				IHCA/Family Alliance/Mds/Caregiving	
							3,212	
							Leadership Training (Deming)	
							3,672	
							Entertainment Expense ( )	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 8,722	

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Il. Health Care Assoc. \$8,800
- (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. \$ 21,623 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. \$ 82,125  
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. \$ 39,440 Has any meal income been offset against related costs? NO 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.