

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center

0040709 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	96	Skilled (SNF)	96	35,040	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	96	TOTALS	96	35,040	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	3,222	955	4,481	8,658	8
9	SNF/PED					9
10	ICF	13,937	4,305	0	18,242	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,159	5,260	4,481	26,900	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.77%

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 03/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/95 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 33 and days of care provided 3,547

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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 Lincoln Rehabilitation & Health Care # 0040709 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				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	197,128	12,510	12,000	221,638	1,129	222,767	(350)	222,417		1
2	Food Purchase		191,423		191,423	(19,132)	172,291	(54,264)	118,027		2
3	Housekeeping	97,337	24,253		121,590	356	121,946	2,176	124,122		3
4	Laundry	53,684	8,760		62,444	429	62,873		62,873		4
5	Heat and Other Utilities			114,614	114,614		114,614	(333)	114,281		5
6	Maintenance	55,413		79,915	135,328	149	135,477	26,673	162,150		6
7	Other (specify):* Related Party Benefits							4,159	4,159		7
8	TOTAL General Services	403,562	236,946	206,529	847,037	(17,069)	829,968	(21,939)	808,029		8
	B. Health Care and Programs										
9	Medical Director			21,100	21,100		21,100		21,100		9
10	Nursing and Medical Records	1,323,977	111,761	5,674	1,441,412	(16,522)	1,424,890	29,747	1,454,637		10
10a	Therapy	16,258			16,258		16,258		16,258		10a
11	Activities	48,768	1,779	2,427	52,974	95	53,069		53,069		11
12	Social Services	37,158			37,158		37,158		37,158		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Benefits							4,603	4,603		15
16	TOTAL Health Care and Programs	1,426,161	113,540	29,201	1,568,902	(16,427)	1,552,475	34,350	1,586,825		16
	C. General Administration										
17	Administrative	52,594			52,594	403	52,997	60,562	113,559		17
18	Directors Fees										18
19	Professional Services			367,004	367,004	(9,941)	357,063	(309,916)	47,147		19
20	Dues, Fees, Subscriptions & Promotions			62,995	62,995		62,995	(56,646)	6,349		20
21	Clerical & General Office Expenses	67,528	14,985	29,464	111,977	729	112,706	152,388	265,094		21
22	Employee Benefits & Payroll Taxes			298,382	298,382	12,890	311,272	(40)	311,232		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,681	6,681	(388)	6,293	1,359	7,652		24
25	Other Admin. Staff Transportation							6,510	6,510		25
26	Insurance-Prop.Liab.Malpractice			98,448	98,448	(436)	98,012	115	98,127		26
27	Other (specify):* Related Party Benefits			57,875	57,875		57,875	(26,980)	30,895		27
28	TOTAL General Administration	120,122	14,985	920,849	1,055,956	3,257	1,059,213	(172,648)	886,565		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,949,845	365,471	1,156,579	3,471,895	(30,239)	3,441,656	(160,237)	3,281,419		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.

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			37,031	37,031		37,031	2,606	39,637			30
31	Amortization of Pre-Op. & Org.							35	35			31
32	Interest			41,946	41,946	436	42,382	14,394	56,776			32
33	Real Estate Taxes			97,548	97,548		97,548	2,574	100,122			33
34	Rent-Facility & Grounds			664,722	664,722		664,722		664,722			34
35	Rent-Equipment & Vehicles			6,377	6,377		6,377	19,681	26,058			35
36	Other (specify):*											36
37	TOTAL Ownership			847,624	847,624	436	848,060	39,290	887,350			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		214,673	281,354	496,027	29,803	525,830	(53,742)	472,088			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		42		42		42	(43)	(1)			41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		214,715	333,914	548,629	29,803	578,432	(53,785)	524,647			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,949,845	580,186	2,338,117	4,868,148		4,868,148	(174,732)	4,693,416			45

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

Reclassifications - Pgs 3 and 4

<u>From</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(19,132.00)	Employee Meals
	22	19,132.00	
10		(29,803.00)	Oxygen Costs
	39	29,803.00	
26		(436.00)	Insurance Expense
	32	436.00	
22		(6,242.00)	Employee Uniforms
	1	1,128.00	
	3	356.00	
	4	430.00	
	6	149.00	
	10	3,743.00	
	11	95.00	
	21	341.00	
19		(9,538.00)	Clinical Coordinators to Ln 10 (Pathway)
	10	9,538.00	
19		(403.00)	Documentation (Wellington Plaza)
	17	403.00	
24		(263.00)	Petty cash - from seminar to office supplies
	21	263.00	
24		(125.00)	Macy's - from seminar to office supplies
	21	125.00	

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				9
10	Interest and Other Investment Income	(13,911)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,135)	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	(2,837)	21		17
18	Fines and Penalties	(1,639)	32		18
19	Entertainment	(2,425)	20		19
20	Contributions	(4,661)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(27,060)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,875)	27		24
25	Fund Raising, Advertising and Promotional	(8,266)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (119,809)		\$	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	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)	(17,611)	various	34
35	Other- Attach Schedule	(37,312)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (54,923)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (174,732)		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

Alden Lincoln Rehabilitation & Health Care Center

ID# 0040709

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees on Utilities	\$ (1,878)	5	1
2	Gift Shop Expenses	(43)	41	2
3	Intercompany Interest	(39,952)	32	3
4				4
5	Miscellaneous Income (medical records)	(90)	10	5
6	Miscellaneous Income (food rebate)	(275)	2	6
7	Miscellaneous Income (vending machine rebate)	(140)	2	7
8	Miscellaneous Income (polling rental)	(425)	6	8
9	Miscellaneous Income (payroll differences)	(30)	21	9
10	Eliminate 29.31% of IHCA PAC Fees	(1,448)	20	10
11	Vendor Settlement - Multiut Corp	(649)	21	11
12	Vendor Settlement - Multiut Corp	649	6	12
13	Vendor Settlement - Chemcraft Industries	(50)	21	13
14	Vendor Settlement - Chemcraft Industries	50	6	14
15	Reduce deprec exp on Pg 13 items <\$2,500 - LPK	(1,600)	30	15
16	Reduce deprec exp on Pg 12 items <\$2,500 - LPK	(542)	30	16
17	Expense capital items >\$2,500 on Pg 13 - LPK	7,324	6	17
18	Expense capital items >\$2,500 on Pg 12 - LPK	4,191	6	18
19	Depreciation adjustment	(5)	30	19
20	Deferred Maintenance adjustment	(1,678)	6	20
21	Back out Lincoln Park Chamber	(560)	20	21
22	Deming Leadership Training adjustment	115	24	22
23	Eliminate Non Care - Employee Benefits	(40)	22	23
24	Eliminate Non Care - Marketing costs	(40)	20	24
25	Eliminate Non Care - G & A costs	(98)	21	25
26	Eliminate Non Care - R & M costs	(98)	6	26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(37,312)		49

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	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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* 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	5 Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 1,545	\$	1,545	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		1,244		1,244	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		6,510		6,510	17
18	V	26 Insurance		Alden Management Services, Inc.		115		115	18
19	V	20 Dues & Subscription	39,510	Alden Management Services, Inc.		264		(39,246)	19
20	V	30 Depreciation		Alden Management Services, Inc.		3,226		3,226	20
21	V	31 Amortization		Alden Management Services, Inc.		35		35	21
22	V	33 Real Estate Tax		Alden Management Services, Inc.		2,382		2,382	22
23	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		19,681		19,681	23
24	V	32 Interest		Alden Management Services, Inc.		69,221		69,221	24
25	V	1 Dietary		Alden Management Services, Inc.		3,121		3,121	25
26	V	3 Housekeeping		Alden Management Services, Inc.		2,176		2,176	26
27	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		3,492		3,492	27
28	V	10 Nursing & Medical records Salaries		Alden Management Services, Inc.		26,367		26,367	28
29	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		4,603		4,603	29
30	V	17 Administrative Salary		Alden Management Services, Inc.		60,562		60,562	30
31	V								31
32	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		28,984		28,984	32
33	V	19 Professional Fees (GL 6801)	306,391	Alden Management Services, Inc.		23,535		(282,856)	33
34	V	21 General & Administrative		Alden Management Services, Inc.		130,839		130,839	34
35	V	6 Repairs and Maintenance	3,114	Alden Management Services, Inc.		19,925		16,811	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 349,015			\$ 407,827	\$ *	58,812	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 Diet Consultant	\$ 12,000	Prism Health Care Services, Inc.	0.00%	\$ 4,124	\$ (7,876)
16	V	1 Dietary Salary		Prism Health Care Services, Inc.		4,405	4,405
17	V	2 Tube Feeding	66,144	Prism Health Care Services, Inc.		13,430	(52,714)
18	V	10 Equipment Rental	3,060	Prism Health Care Services, Inc.		4,767	1,707
19	V	39 Ancillary Supplies	55,322	Prism Health Care Services, Inc.		27,690	(27,632)
20	V	21 Gen & Admin Salary		Prism Health Care Services, Inc.		5,908	5,908
21	V	27 Employee Benefits		Prism Health Care Services, Inc.		1,386	1,386
22	V	7 Employee Benefits		Prism Health Care Services, Inc.		667	667
23	V	21 General & Administrative		Prism Health Care Services, Inc.		8,938	8,938
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 136,526			\$ 71,315	\$ * (65,211)

* 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 <u>Drugs</u>	\$ 80,482	<u>Forum Extended Care Services II, Inc.</u>	0.00%	\$ 119,372	\$ 38,890
16	V	39 <u>IV</u>	60,522	<u>Forum Extended Care Services II, Inc.</u>		6,640	(53,882)
17	V	39 <u>Wound Care</u>	6,017	<u>Forum Extended Care Services II, Inc.</u>		4,779	(1,238)
18	V	10 <u>House Stock</u>	3,954	<u>Forum Extended Care Services II, Inc.</u>		3,773	(181)
19	V	10 <u>Pharmacy Consultant</u>	5,644	<u>Forum Extended Care Services II, Inc.</u>		7,588	1,944
20	V	27 <u>Employee Vaccination</u>	965	<u>Forum Extended Care Services II, Inc.</u>		757	(208)
21	V	27 <u>Employee Benefits: G&A</u>		<u>Forum Extended Care Services II, Inc.</u>		733	733
22	V	21 <u>Gen'l & Admin. Salary</u>		<u>Forum Extended Care Services II, Inc.</u>		5,562	5,562
23	V	21 <u>Gen'l & Admin.</u>		<u>Forum Extended Care Services II, Inc.</u>		4,805	4,805
24	V	32 <u>Interest</u>		<u>Forum Extended Care Services II, Inc.</u>		590	590
25	V	33 <u>Real Estate Tax</u>		<u>Forum Extended Care Services II, Inc.</u>		192	192
26	V	30 <u>Depreciation</u>		<u>Forum Extended Care Services II, Inc.</u>		1,527	1,527
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 157,584			\$ 156,318	\$ * (1,266)

* 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 Therapy	\$ 272,180	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 262,300	\$ (9,880)
16	V	32 Interest				85	85
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 272,180			\$ 262,385	\$ * (9,795)

* 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 and Maintenance	\$ 11,013	Alden Bennett Construction Company, Inc.	0.00%	\$ 10,862	\$	(151)	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		\$ 11,013			\$ 10,862	\$ *	(151)	39

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

Facility Name & ID Number

Alden Lincoln Rehabilitation & Health Care Center Provider No. 0040709

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 Lincoln Rehabilitation & Health Care # 0040709 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	167,016	0.932	0.02	Salary	\$ 3,984	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	62,978	0.932	0.02	Salary	1,502	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	37,076	0.932	0.02	Salary	884	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	\$ 6,370		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 Lincoln Rehabilitation & Health Care Center

0040709

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	5	Utilities	Patient Days	1,154,703	29	\$ 66,329	\$ 26,900	\$ 1,545	1	
2	24	Travel & Seminar	Patient Days	1,154,703	29	53,403	26,900	1,244	2	
3	25	Other Admin Travel	Patient Days	1,154,703	29	279,431	26,900	6,510	3	
4	26	Insurance	Patient Days	1,154,703	29	4,925	26,900	115	4	
5	20	Dues & Subscription	Patient Days	1,154,703	29	11,328	26,900	264	5	
6	30	Depreciation	No. of Providers/Usage	29	29	93,554	1	3,226	6	
7	31	Amortization	Patient Days	1,154,703	29	1,500	26,900	35	7	
8	33	Real Estate Tax	Patient Days	1,154,703	29	102,244	26,900	2,382	8	
9	35	Rent - Equipment & Vehicles	Patient Days	1,154,703	29	844,835	26,900	19,681	9	
10	32	Interest	Patient Days	1,154,703	29	2,971,361	26,900	69,221	10	
11	1	Dietary	Patient Days	1,154,703	29	133,965	133,965	26,900	3,121	11
12	3	Housekeeping	Patient Days	1,154,703	29	93,421	93,421	26,900	2,176	12
13	7	Employee Benefits - Gen'l Services	Patient Days	1,154,703	29	149,914	26,900	3,492	13	
14	10	Nursing & Medical records Salaries	Patient Days	1,154,703	29	1,131,824	1,178,420	26,900	26,367	14
15	15	Employee Benefits - Health Care	Patient Days	1,154,703	29	197,574	26,900	4,603	15	
16	17	Administrative Salary	Patient Days/usage	1,154,703	29	2,599,670	1,091,420	26,900	60,562	16
17									17	
18	27	Employee Benefits - Admin	Patient Days	1,154,703	29	1,244,181	26,900	28,984	18	
19	19	Professional Fees (GL 6801)	Patient Days	1,154,703	29	1,010,272	531,592	26,900	23,535	19
20	21	General & Administrative	Patient Days	1,154,703	29	5,616,348	4,942,836	26,900	130,839	20
21	6	Repairs and Maintenance	Patient Days	1,154,703	29	855,298	666,770	26,900	19,925	21
22									22	
23									23	
24									24	
25	TOTALS					\$ 17,461,377	\$ 8,638,424	\$ 407,827	25	

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5	Insurance Interest-see reclass	x	Malpractice insurance						436	5										
Working Capital																				
6	Related Party - CPT	x							85	6										
7	Related Party - AMS	x							69,576	7										
8	Related Party - FECII	x							590	8										
9	TOTAL Facility Related								70,687	9										
B. Non-Facility Related*																				
10	Interest Inc (Corp) 4646/4975								(13,911)	10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related								(13,911)	14										
15	TOTALS (line 9+line14)								56,776	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* 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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	122,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	108,548	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(14,252)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	111,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	97,548	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	150,743	8
	2003	115,451	9
	2004	118,016	10
	2005	119,217	11
	2006	108,548	12

The current year accrual is based on an estimated 3% increase of the prior year tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Lincoln Rehabilitation & Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040709

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 Ser</u>	\$ <u>241,399.00</u>	\$ <u>2,382.00</u>
2. <u>See Attached (12 Pg Supplement)</u>	<u>Related Party-Forum Professional Cen</u>	\$ <u>37,806.00</u>	\$ <u>192.00</u>
3. <u>14-28-108-023-0000</u>	<u>Nursing Home Facility</u>	\$ <u>108,548.00</u>	\$ <u>108,548.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>387,753.00</u>	\$ <u>111,122.00</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 Lincoln Rehabilitation & Health Care Center

0040709

Report Period Beginning:

1/1/07

Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center

0040709

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8	Related Party-Forum		1978		14,541		25			14,541	8
	Improvement Type**										
9	Sprinkler heads		1995		1,832	73	25	73		897	9
10	Roof repairs		1995		2,000		10			2,000	10
11	Installed Electric AMPS		1996		1,870		5			1,870	11
12	Signs		1996		1,800		10			1,800	12
13	Water Heater		1997		6,180		5			6,180	13
14	Replace Pipes		1997		5,949		5			5,949	14
15	Exhaust Fans		1997		8,403		5			8,403	15
16	Washing machine motor		1998		1,576		8			1,576	16
17	ABC (General construction) Major repairs/improvement		1999		5,713	571	10	571		4,855	17
18	ABC (General construction) Major repairs/improvement		1999		2,326	233	10	233		1,959	18
19	ABC (General construction) Major repairs/improvement		1999		2,092	209	10	209		1,760	19
20	ABC (General construction) Major repairs/improvement		1999		1,870	187	10	187		1,527	20
21	ABC (General construction) Major repairs/improvement		1999		12,658	1,266	10	1,266		10,338	21
22	ABC (General construction) Major repairs/improvement		1999		2,250	225	10	225		1,819	22
23	ABC (General construction) Major repairs/improvement		1999		10,225	1,022	10	1,022		8,264	23
24	Climate Services (exhaust fan)		1999		2,280		5			2,280	24
25	Oxygen exhaust system		2000		8,555	1,069	8	1,069		8,465	25
26	Elevator door repair		2000		1,518		5			1,518	26
27	Lawn Sprinkler		2000		15,500	620	25	620		4,547	27
28	ABC (General construction) Major repairs/improvement		2000		6,937		5			6,937	28
29	ABC (General construction) New hot water system		2000		49,596	2,480	20	2,480		19,426	29
30	ABC (General construction) Replace showers		2000		23,903	2,390	10	2,390		17,528	30
31	Replace Fire Pump		2001		3,230	162	20	162		1,132	31
32	14 Kilowatt water heater booster		2001		2,783	278	10	278		1,762	32
33	ABC (General construction) Major repairs/improvement		2001		3,402		5			3,402	33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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	Capps Plumbing (pipe & wall repair)	2002	\$ 1,985	\$ 298	5	\$ 298	\$	\$ 1,985	37
38	ABC (misc construction work)	2002	3,442	460	5	460		3,442	38
39	ABC (repair ejector pump)	2002	7,893	1,183	5	1,183		7,893	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		888	40
41	TNS (DSL Cable)	2004	1,358	271	5	271		1,062	41
42	ABC (1st Floors Stairs)	2004	1,699	170	10	170		524	42
43	Oak Fire security System, new base dual zone card	2005	1,350	270	5	270		563	43
44	Washtown (repair Washer motor)	2005	1,563	313	5	313		756	44
45	ABC (repair Mop basin)	2005	1,613	323	5	323		780	45
46									46
47	ABC - seal holes and replace fill materials 3rd floor	2006	5,793	579	10	579		1,013	47
48	TopNotch - booster heater	2006	3,217	322	10	322		402	48
49									49
50	ABC - wall covering	2007	10,494	700	10	700		700	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									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)		\$ 242,671	\$ 15,839		\$ 15,839	\$	\$ 160,743	70

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

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center

0040709

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		\$ 242,671	\$ 15,839		\$ 15,839	\$	\$ 160,743	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	10,485	266	30	266		2,420	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 322,769	\$ 18,650		\$ 18,650	\$	\$ 226,019	34

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

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	\$ 179,216	\$ 18,590	\$ 18,590	\$	various	\$ 110,096	71
72	Current Year Purchases	23,417	1,406	1,406		various	1,406	72
73	Fully Depreciated Assets	127,854	962	962		various	127,854	73
74								74
75	TOTALS	\$ 330,487	\$ 20,958	\$ 20,958	\$		\$ 239,356	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)	\$ 653,374	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,637	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,637	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 465,492	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: TL Enterprises

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:		<u>96</u>		\$ <u>664,722</u>	<u>16</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>96</u>		\$ <u>664,722</u>			7

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

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

9. Option to Buy: YES NO Terms: Purchase Option deposit *

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: \$ 6,378 Description: copy machine lease (GL 6861)

(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 (6A)</u>	<u>various</u>	\$ <u>934.25</u>	\$ <u>11,211</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>934.25</u>	\$ <u>11,211</u>	21

10. Effective dates of current rental agreement:

Beginning 03/01/95

Ending 03/01/10

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

Fiscal Year Ending Annual Rent

12. 12/31/08 \$ varies

13. 12/31/09 \$ varies

14. 12/31/10 \$ varies

* 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	\$		\$ 138,413	\$		\$ 138,413	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,238			6,238	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			127,529			127,529	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				119,372		119,372	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					(9,881)	90,417		80,536	13
14	TOTAL			\$		\$ 262,299	\$ 209,789		\$ 472,088	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	\$138,413.05
2. ST	39-3	To Col 5	6,237.69
3.			
4. PT	39-3	To Col 5	127,529.59
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			80,481.76
Manual Input from Related Party- Forum Drugs			38,890.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	119,371.76
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	(9,881.00)
Other			143,364.94
Manual Input: Related Party - Pyramid			(27,632.00)
Manual Input: Related Party FECII - I.V.			(53,882.00)
Manual Input: Related Party FECII - Wound Care			(1,237.00)
Oxygen, from reclass worksheet			29,803.00
13. Col 6: Supplies Total		To Col 6	90,416.94
13. Total Line 13, Column 8			90,416.94
14. Total			472,088.03

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center # 0040709 Report 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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>61,500</u>)	805,148		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,543		6
7	Other Prepaid Expenses	13,298		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd Parties</u>	11,619		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 833,608	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	321,405		15
16	Equipment, at Historical Cost	262,501		16
17	Accumulated Depreciation (book methods)	(391,434)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	165,990		21
22	Other Long-Term Assets (specify: <u>Purchase Option</u>)	288,000		22
23	Other(specify): <u>Due from Affiliates</u>	184,108		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 830,570	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,664,178	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 548,012	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	123,714		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,285		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,512		31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued exp/Deferred Rent</u>	316,923		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,340,246	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,340,246	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 323,932	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,664,178	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 723,019	1
2	Restatements (describe):		2
3	external audit adjustment made after 2006 cost report was	27,101	3
4	submitted. These have no effect on prior years report.		4
5	Bad Debt, Medicare revenues (non allowables).		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 750,120	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(426,188)	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)	\$ (426,188)	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)	\$ 323,932	24 *

* This must agree with page 17, line 47.

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	\$ 4,328,157	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,328,157	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	45,489	6
7	Oxygen	20,012	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 65,501	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	315	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,817	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,132	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,911	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,911	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	960	28
28a	Adjustment to Prior Year's exp	20,299	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,259	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,441,960	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	847,037	31
32	Health Care	1,568,902	32
33	General Administration	1,055,956	33
	B. Capital Expense		
34	Ownership	847,624	34
	C. Ancillary Expense		
35	Special Cost Centers	496,069	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,868,148	40
41	Income before Income Taxes (line 30 minus line 40)**	(426,188)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (426,188)	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 Lincoln Rehabilitation & Health Care Center

0040709

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	505	509	\$ 17,533	\$ 34.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,903	13,796	429,915	31.16	3
4	Licensed Practical Nurses	12,074	12,461	326,525	26.20	4
5	CNAs & Orderlies	40,949	45,171	493,249	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,632	1,632	28,327	17.36	9
10	Activity Assistants	2,181	2,407	20,441	8.49	10
11	Social Service Workers	2,072	2,072	37,158	17.93	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,080	42,425	20.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,672	13,826	154,703	11.19	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	55,413	26.64	17
18	Housekeepers	9,425	10,216	97,337	9.53	18
19	Laundry	5,200	5,696	53,684	9.42	19
20	Administrator	1,454	1,454	52,594	36.17	20
21	Assistant Administrator					21
22	Other Administrative	2,574	2,606	64,356	24.70	22
23	Office Manager					23
24	Clerical	2,152	2,283	19,430	8.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,648	1,648	29,714	18.03	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Alzheimer Supervi	2,032	2,040	27,041	13.26	33
34	TOTAL (lines 1 - 33)	113,569	121,977	\$ 1,949,845 *	\$ 15.99	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	1000/monthly	\$ 12,000	1-3	35
36	Medical Director	1758/monthly	21,100	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192/monthly	2,304	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	124/monthly	1,490	11-3	44
45	Social Service Consultant	64/monthly	768	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,662		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 Lincoln Rehabilitation & Health Care Center
Legal Fee Support
2007

Pg 21A

Legal Fees Reported on Pg 21, Section C:	40,549.00
Less: Collection, estates & other non-allowable legal fees listed on Pg 5, Ln 19	(27,060.00)
Less: Non-allowable legal fees, if any, deducted on Pg 5A	<hr/>
Allowable Legal Fees	<hr/> <hr/> 13,489.00

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center

0040709

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. II. Health Care Assoc. \$4,293
- (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. \$ 19,147 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. \$ 52,560
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. \$ 19,132 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