

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028 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	93	Skilled (SNF)	93	33,945	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	93	TOTALS	93	33,945	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	4	2,330	17,208	19,542	8
9	SNF/PED					9
10	ICF	730	5,046		5,776	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	734	7,376	17,208	25,318	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.59%

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 8/14/99

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/14/99 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 93 and days of care provided 17,190

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 North Shore Rehab & HCC # 0042028 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	499,973	29,869	2,400	532,242	934	533,176	2,243	535,419		1
2	Food Purchase		264,745		264,745	(30,024)	234,721	(9,853)	224,868		2
3	Housekeeping	98,668	33,858		132,526	824	133,350	2,048	135,398		3
4	Laundry	60,538	19,474	340	80,352	240	80,592		80,592		4
5	Heat and Other Utilities			182,673	182,673		182,673	(3,688)	178,985		5
6	Maintenance	53,871		149,175	203,046	159	203,205	20,443	223,648		6
7	Other (specify):* Related Party							3,790	3,790		7
8	TOTAL General Services	713,050	347,946	334,588	1,395,584	(27,867)	1,367,717	14,983	1,382,700		8
	B. Health Care and Programs										
9	Medical Director			114,500	114,500		114,500		114,500		9
10	Nursing and Medical Records	1,958,956	123,667	8,508	2,091,131	12,293	2,103,424	28,015	2,131,439		10
10a	Therapy	71,880	2,475		74,355		74,355		74,355		10a
11	Activities	75,900		6,359	82,259		82,259		82,259		11
12	Social Services	40,338			40,338		40,338		40,338		12
13	CNA Training										13
14	Program Transportation			530	530		530		530		14
15	Other (specify):* Related Party							4,332	4,332		15
16	TOTAL Health Care and Programs	2,147,074	126,142	129,897	2,403,113	12,293	2,415,406	32,347	2,447,753		16
	C. General Administration										
17	Administrative	176,565			176,565		176,565	33,817	210,382		17
18	Directors Fees										18
19	Professional Services			834,553	834,553	(7,486)	827,067	(770,578)	56,490		19
20	Dues, Fees, Subscriptions & Promotions			79,530	79,530		79,530	(69,801)	9,729		20
21	Clerical & General Office Expenses	106,802	38,179	112,175	257,156	465	257,621	122,577	380,198		21
22	Employee Benefits & Payroll Taxes			400,864	400,864	22,595	423,459	(959)	422,500		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,073	8,073		8,073	716	8,789		24
25	Other Admin. Staff Transportation			8,809	8,809		8,809	6,127	14,936		25
26	Insurance-Prop.Liab.Malpractice			90,100	90,100	(422)	89,678	10,252	99,930		26
27	Other (specify):* Related Party			16,593	16,593		16,593	14,472	31,065		27
28	TOTAL General Administration	283,367	38,179	1,550,697	1,872,243	15,152	1,887,395	(653,377)	1,234,018		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,143,491	512,267	2,015,182	5,670,940	(422)	5,670,518	(606,047)	5,064,471		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Alden North Shore Rehab & HCC

#0042028

Report Period Beginning:

1/1/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			47,155	47,155		47,155	217,219	264,374			30
31	Amortization of Pre-Op. & Org.							7,303	7,303			31
32	Interest			348,382	348,382	422	348,804	356,837	705,641			32
33	Real Estate Taxes							246,914	246,914			33
34	Rent-Facility & Grounds			947,529	947,529		947,529	(947,529)				34
35	Rent-Equipment & Vehicles			11,540	11,540		11,540	18,524	30,064			35
36	Other (specify):*							65,816	65,816			36
37	TOTAL Ownership			1,354,606	1,354,606	422	1,355,028	(34,916)	1,320,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		768,155	1,342,021	2,110,176		2,110,176	10,781	2,120,957			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		304		304		304	(304)				41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):* MIP											43
44	TOTAL Special Cost Centers		768,459	1,392,939	2,161,398		2,161,398	10,477	2,171,875			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,143,491	1,280,726	4,762,727	9,186,944		9,186,944	(630,486)	8,556,458			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		(30,024.00)	Employee Meals
	22	30,024.00	
26		(422.00)	Insurance Expense
	32	422.00	
22		(7,428.97)	Employee Uniforms
	1	933.78	
	3	823.67	
	4	240.51	
	6	158.63	
	10	5,086.21	
	11		
	21	186.17	
19		(7,207.00)	Clinical Coordinators (Pathway) to LN 10
	10	7,207.00	Clinical Coordinators (Pathway) to LN 10
19		(279.00)	Reclass Exam Fee from Professional to G & A
	21	279.00	Reclass Exam Fee from Professional to G & A
		-	

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	(149)	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	(65,940)	30		9
10	Interest and Other Investment Income	(2,094)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,648)	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	(2,544)	21		17
18	Fines and Penalties	(1,540)	32		18
19	Entertainment	(744)	20		19
20	Contributions	(2,769)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,064)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,593)	27		24
25	Fund Raising, Advertising and Promotional	(22,860)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(287)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (132,232)		\$	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)	(366,147)		34
35	Other- Attach Schedule	(132,107)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (498,254)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (630,486)		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 North Shore Rehab & HCC

ID# 0042028

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Valet Cost	\$ (43,483)	21	1
2	Late Fees on Utilities	(5,142)	5	2
3	Late Fees on Telephone	(548)	21	3
4	Gift Shop Expenses	(304)	41	4
5	Intercompany Interest	(77,577)	32	5
6				6
7	Miscellaneous Income - Food Vendor Rebate	(492)	2	7
8	Miscellaneous Income - Medical Records	(1,707)	10	8
9	Back Out 29.31% of PAC Fees from ILHCA bills	(1,505)	20	9
10	Vendor Settlement - Richard Czeck	(8,570)	21	10
11	Vendor Settlement - Richard Czeck	8,570	6	11
12	Vendor Settlement - Multiut Corporation	(800)	21	12
13	Vendor Settlement - Multiut Corporation	800	6	13
14				14
15	Reduce Deprec exp on Pg 13 items under \$2,500	(1,044)	30	15
16	Reduce Deprec exp on Pg 12 items under \$2,500	(408)	30	16
17	Expense Capital Items < \$2,500 on Pg 13 items	5,723	6	17
18	Expense Capital Items < \$2,500 on Pg 12 items	2,742	6	18
19	Additional Leadership Training (Deming) Adjustment	145	24	19
20				20
21	Eliminate non-care employee benefits	(959)	22	21
22	Eliminate non-care marketing costs	(2,724)	20	22
23	Eliminate non-care G & A costs	(1,018)	21	23
24	Eliminate non-care R & M costs	(1,018)	6	24
25				25
26	Back Out PAC Fees	(600)	24	26
27	Eliminate Legal Fee reimbursable by insurance	(2,188)	19	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	(132,107)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	2,937	(694)	0	0	0	0	0	0	0	2,243	1
2	Food Purchase	(2,289)	0	0	(7,564)	0	0	0	0	0	0	0	(9,853)	2
3	Housekeeping	0	0	2,048	0	0	0	0	0	0	0	0	2,048	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,142)	0	1,454	0	0	0	0	0	0	0	0	(3,688)	5
6	Maintenance	16,817	0	3,953	0	0	0	(327)	0	0	0	0	20,443	6
7	Other (specify):*	0	0	3,287	503	0	0	0	0	0	0	0	3,790	7
8	TOTAL General Services	9,386	0	13,679	(7,755)	0	0	(327)	0	0	0	0	14,983	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,707)	0	24,816	1,707	3,199	0	0	0	0	0	0	28,015	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	4,332	0	0	0	0	0	0	0	0	4,332	15
16	TOTAL Health Care and Programs	(1,707)	0	29,148	1,707	3,199	0	0	0	0	0	0	32,347	16
	C. General Administration													
17	Administrative	0	0	33,817	0	0	0	0	0	0	0	0	33,817	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,252)	9,107	(762,433)	0	0	0	0	0	0	0	0	(770,578)	19
20	Fees, Subscriptions & Promotions	(30,889)	350	(39,262)	0	0	0	0	0	0	0	0	(69,801)	20
21	Clerical & General Office Expenses	(56,963)	0	123,144	11,197	45,199	0	0	0	0	0	0	122,577	21
22	Employee Benefits & Payroll Taxes	(959)	0	0	0	0	0	0	0	0	0	0	(959)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(455)	0	1,171	0	0	0	0	0	0	0	0	716	24
25	Other Admin. Staff Transportation	0	0	6,127	0	0	0	0	0	0	0	0	6,127	25
26	Insurance-Prop.Liab.Malpractice	0	10,144	108	0	0	0	0	0	0	0	0	10,252	26
27	Other (specify):*	(16,593)	0	27,280	1,046	2,739	0	0	0	0	0	0	14,472	27
28	TOTAL General Administration	(123,111)	19,601	(610,048)	12,243	47,938	0	0	0	0	0	0	(653,377)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(115,432)	19,601	(567,221)	6,195	51,137	0	(327)	0	0	0	0	(606,047)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(67,392)	279,858	3,226	0	1,527	0	0	0	0	0	0	217,219	30
31	Amortization of Pre-Op. & Org.	0	7,270	33	0	0	0	0	0	0	0	0	7,303	31
32	Interest	(81,211)	428,291	6,781	0	2,571	405	0	0	0	0	0	356,837	32
33	Real Estate Taxes	0	243,836	2,242	0	836	0	0	0	0	0	0	246,914	33
34	Rent-Facility & Grounds	0	(947,529)	0	0	0	0	0	0	0	0	0	(947,529)	34
35	Rent-Equipment & Vehicles	0	0	18,524	0	0	0	0	0	0	0	0	18,524	35
36	Other (specify):*	0	65,816	0	0	0	0	0	0	0	0	0	65,816	36
37	TOTAL Ownership	(148,603)	77,542	30,806	0	4,934	405	0	0	0	0	0	(34,916)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(44,565)	(115,571)	170,917	0	0	0	0	0	10,781	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(304)	0	0	0	0	0	0	0	0	0	0	(304)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(304)	0	0	(44,565)	(115,571)	170,917	0	0	0	0	0	10,477	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(264,339)	97,143	(536,415)	(38,370)	(59,500)	171,322	(327)	0	0	0	0	(630,486)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6L		See Pg 6K	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 947,529	Alden North Shore Associated Limited Partnership		\$ (947,529)	1
2	V	32	Interest Income - RR	3,938	Alden North Shore Associated Limited Partnership		(3,938)	2
3	V	32	Interest Income - Misc	169,419	Alden North Shore Associated Limited Partnership		(169,419)	3
4	V	19	Accounting Fees		Alden North Shore Associated Limited Partnership		4,850	4
5	V	19	Legal Fees: Non-Collections		Alden North Shore Associated Limited Partnership		4,194	5
6	V	33	Real Estate Tax		Alden North Shore Associated Limited Partnership		243,836	6
7	V	26	Property & Liab Insur		Alden North Shore Associated Limited Partnership		10,144	7
8	V	32	Interest on Motgage Note		Alden North Shore Associated Limited Partnership		601,648	8
9	V	36	Mortgage Insur Premium		Alden North Shore Associated Limited Partnership		65,816	9
10	V	30	Depreciation		Alden North Shore Associated Limited Partnership		279,858	10
11	V	31	Amortization		Alden North Shore Associated Limited Partnership		7,270	11
12	V	19	Bank Charges		Alden North Shore Associated Limited Partnership		63	12
13	V	20	Dues & Subscriptions		Alden North Shore Associated Limited Partnership		350	13
14	Total		\$ 1,120,886			\$ 1,218,029	\$ * 97,143	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	19 Professional Fees	\$ 784,584	Alden Management Services, Inc.	0.00%	\$ 22,151	\$ (762,433)
16	V	5 Utilities		Alden Management Services, Inc.		1,454	1,454
17	V	24 Travel & Seminar		Alden Management Services, Inc.		1,171	1,171
18	V	25 Other Admin Travel		Alden Management Services, Inc.		6,127	6,127
19	V	26 Forum Allocated Insurance		Alden Management Services, Inc.		108	108
20	V	20 Dues, Subscriptions	39,510	Alden Management Services, Inc.		248	(39,262)
21	V	30 Depreciation		Alden Management Services, Inc.		3,226	3,226
22	V	31 Amortization		Alden Management Services, Inc.		33	33
23	V	33 Real Estate Tax		Alden Management Services, Inc.		2,242	2,242
24	V	35 Rent - Equip & Vehic.		Alden Management Services, Inc.		18,524	18,524
25	V	32 Interest		Alden Management Services, Inc.		6,781	6,781
26	V	1 Dietary Aide Coordinator Salary		Alden Management Services, Inc.		2,937	2,937
27	V	3 Housekeeping Coordinator		Alden Management Services, Inc.		2,048	2,048
28	V	7 Employee Benefit % - Gen'l Servs		Alden Management Services, Inc.		3,287	3,287
29	V	10 Nurse & Med Records Salary		Alden Management Services, Inc.		24,816	24,816
30	V	15 Employee Benefit % - Health Care		Alden Management Services, Inc.		4,332	4,332
31	V	17 Administrative Salary		Alden Management Services, Inc.		33,817	33,817
32	V						
33	V	27 Employee Benefits % - Administrat		Alden Management Services, Inc.		27,280	27,280
34	V	21 Gen'l & Admin: Salary & Non-Salary		Alden Management Services, Inc.		123,144	123,144
35	V	6 Repair & Maint: Salary & Non-Salary	14,800	Alden Management Services, Inc.		18,753	3,953
36	V						
37	V						
38	V						
39	Total		\$ 838,894			\$ 302,479	\$ * (536,415)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Consultant	\$ 2,400	Prism Health Care Services, Inc.	0.00%	\$ 1,706	\$ (694)
16	V	2 Tube Feeding	14,937	Prism Health Care Services, Inc.		7,373	(7,564)
17	V	10 Equipment Rental	3,060	Prism Health Care Services, Inc.		4,767	1,707
18	V	39 Supplies	82,574	Prism Health Care Services, Inc.		38,009	(44,565)
19	V	39 Vent Rental		Prism Health Care Services, Inc.			
20	V	21 Salary G & A		Prism Health Care Services, Inc.		4,456	4,456
21	V	27 Employee Benefits		Prism Health Care Services, Inc.		1,046	1,046
22	V	7 Employee Benefits		Prism Health Care Services, Inc.		503	503
23	V	21 G & A		Prism Health Care Services, Inc.		6,741	6,741
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		\$ 102,971			\$ 64,601	\$ * (38,370)

* 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 Drugs	\$ 350,429	Forum Extended Care Services II, Inc.	0.00%	\$ 519,762	\$ 169,333
16	V	39 I.V.	319,952	Forum Extended Care Services II, Inc.		35,103	(284,849)
17	V	39 Wound Care	265	Forum Extended Care Services II, Inc.		210	(55)
18	V	10 House Stock	4,425	Forum Extended Care Services II, Inc.		4,223	(202)
19	V	10 Pharmacy Consultant	9,872	Forum Extended Care Services II, Inc.		13,273	3,401
20	V	27 Employee Vaccinations	2,113	Forum Extended Care Services II, Inc.		1,657	(456)
21	V	27 Employee Benefits: G & A		Forum Extended Care Services II, Inc.		3,195	3,195
22	V	21 Salary: G & A		Forum Extended Care Services II, Inc.		24,249	24,249
23	V	21 Gen'l & Admin		Forum Extended Care Services II, Inc.		20,950	20,950
24	V	32 Interest		Forum Extended Care Services II, Inc.		2,571	2,571
25	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		836	836
26	V	30 Depreciation		Forum Extended Care Services II, Inc.		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		\$ 687,056			\$ 627,556	\$ * (59,500)

* 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	\$ 1,291,991	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,462,908	\$ 170,917	15
16	V	32 Interest		Community Physical Therapy & Associates, Ltd.		405	405	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		\$ 1,291,991			\$ 1,463,313	\$ * 171,322	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Maintenance Expense	\$ 23,977	Alden Bennett Construction Company, Inc.	0.00%	\$ 23,650	\$ (327)
16	V						
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		\$ 23,977			\$ 23,650	\$ * (327)

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

Facility Name & ID Number

Alden - North Shore Rehabilitation and Health Care Provider No.

004-2028

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			

**INVESTOR LIST AND PERCENTAGES
AS OF DECEMBER 31, 2007**

6L

NAME	16,500
	NS
FLOYD A. SCHLOSSBERG	22.00
Lauren Magnusson	1.67
JOAN/SAM CARL	7.50
AMI PISSETZKY	1.00
ROBERT MOLITOR	0.50
MARY CHELOTTI-SMITH	0.50
LAUREN & TERRY MAGNUSSION	1.00
Others	65.84
TOTALS	100.00

Facility Name & ID Number

Alden North Shore Rehab & HCC

#

0042028

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	27.00	167,251	0.876	0.02	Salary	\$ 3,749	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	1.00	63,066	0.876	0.02	Salary	1,414	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	37,128	0.876	0.02	Salary	832	6-7	3
4	Joan Carl	Secretary	Vice-President	7.50	167,251	0.876	0.02	Salary	3,749	17-7	4
5											5
6	Ami Pissetzki	finance relations	invest/bank	1.00	167,251	0.876	0.02	Salary	3,749	17-7	6
7	Bob Molitor	Vp of Operations	operations	0.50	167,251	0.876	0.02	Salary	3,749	17-7	7
8	Mary Chelotti Smith	In-house counsel	legal advis.	0.50	167,251	0.876	0.02	Salary	3,749	19-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,991		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 North Shore Rehab & HCC # 0042028 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	2	3	4	5	6		7		8		
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1								\$		1	
2	Summary...									2	
3	Ami Pissetzki	finance relations	invest/bank	1.00	167,251	0.876	0.02	Salary	3,749	17-7	3
4	Bob Molitor	Vp of Operations	operations	0.50	167,251	0.876	0.02	Salary	3,749	17-7	4
5	Mary Chelotti Smith	In-house counsel	legal advis.	0.50	167,251	0.876	0.02	Salary	3,749	19-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12					501,753						12
13								TOTAL	\$ 11,247		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 North Shore Rehab & HCC

0042028

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	\$ 25,318	\$ 1,454	1
2	24	Trav & Seminar	Patient Days	1,154,703	29	53,403	25,318	1,171	2
3	25	Other Admin Travel	Patient Days	1,154,703	29	279,431	25,318	6,127	3
4	26	Insurance	Patient Days	1,154,703	29	4,925	25,318	108	4
5	20	Dues & Subscriptions	Patient Days	1,154,703	29	11,328	25,318	248	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	25,318	33	7
8	33	Real Estate Tax	Patient Days/usage	1,154,703	29	102,253	25,318	2,242	8
9	35	Rent - Equip & Vehicles	Patient Days	1,154,703	29	844,835	25,318	18,524	9
10	32	Interest	Patient Days/usage	1,154,703	29	309,268	25,318	6,781	10
11	1	Dietary	Patient Days	1,154,703	29	133,965	133,965	2,937	11
12	3	Housekeeping	Patient Days	1,154,703	29	93,421	93,421	2,048	12
13	7	Employee Benefits - Gen'l Servs	Patient Days	1,154,703	29	149,914	25,318	3,287	13
14	10	Nur & Med Records Salary	Patient Days	1,154,703	29	1,131,808	1,178,420	24,816	14
15	15	Employee Benefits - Health Care	Patient Days	1,154,703	29	197,574	25,318	4,332	15
16	17	Administrative Salary	Patient Days/usage	1,154,703	29	1,542,325	1,091,420	33,817	16
17									17
18	27	Employee Benefits - Admin	Patient Days	1,154,703	29	1,244,181	25,318	27,280	18
19	19	Professional Fees	Patient Days	1,154,703	29	1,010,272	531,592	22,151	19
20	21	Gen'l & Admin	Patient Days	1,154,703	29	5,616,348	4,942,836	123,144	20
21	6	Repair & Maint.	Patient Days	1,154,703	29	855,287	666,770	18,753	21
22									22
23									23
24									24
25	TOTALS					\$ 13,741,921	\$ 8,638,424	\$ 302,479	25

Facility Name & ID Number

Alden North Shore Rehab & HCC

0042028

Report Period Beginning:

1/1/07

Ending:

12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Cambridge		X	Mortgage	\$42,694.00	08/01/05	\$ 8,388,000	\$ 8,240,715	7/31/2045	5.4000	\$ 432,076	1						
2	Cambridge		X	Oper Loss Loan	\$16,822.00	08/01/03	3,098,700	2,962,543	8/31/2039	5.6900	169,572	2						
3	Bank Leumi (GL 7053)		X	LOC	\$15,000.00	06/01/05	1,200,000	1,084,498	06/01/08	Varies	99,845	3						
4												4						
5	Insurance Interest-see reclass		x	Malpractice Insurance							422	5						
	Working Capital																	
6	Related Party - CPT	X		Working Capital							405	6						
7	Related Party - AMS	X		Working Capital							6,781	7						
8	Related Party - FECII	X		Working Capital							2,571	8						
9	TOTAL Facility Related				\$74,516.00		\$ 12,686,700	\$ 12,287,756			\$ 711,673	9						
	B. Non-Facility Related*																	
10	Interest Income - RR		X								(3,938)	10						
11	Interest Income - Corp		X								(2,094)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (6,032)	14						
15	TOTALS (line 9+line14)						\$ 12,686,700	\$ 12,287,756			\$ 705,641	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 65,816 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.)

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.		\$	219,900	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.)		\$	228,436	2
3. Under or (over) accrual (line 2 minus line 1).		\$	8,536	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	235,300	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.		\$	243,836	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	190,237	8
	2003	207,104	9
	2004	208,042	10
	2005	213,475	11
	2006	228,436	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 North Shore Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

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>2,242.00</u>
2. <u>See Attached (12 Pg Supplement)</u>	<u>Related Party-Forum Professional Cen</u>	\$ <u>37,806.00</u>	\$ <u>836.00</u>
3. <u>10-28-429-015-0000</u>	<u>Nursing Home Facility</u>	\$ <u>3,014.95</u>	\$ <u>3,014.95</u>
4. <u>10-28-429-016-0000</u>	<u>Nursing Home Facility</u>	\$ <u>2,218.87</u>	\$ <u>2,218.87</u>
5. <u>10-28-429-017-0000</u>	<u>Nursing Home Facility</u>	\$ <u>6,140.15</u>	\$ <u>6,140.15</u>
6. <u>10-28-429-018-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,252.75</u>	\$ <u>22,252.72</u>
7. <u>10-28-429-019-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,263.86</u>	\$ <u>22,263.86</u>
8. <u>10-28-429-020-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,104.54</u>	\$ <u>22,104.54</u>
9. <u>10-28-429-021-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,104.54</u>	\$ <u>22,104.54</u>
10. <u>10-28-429-022-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,085.08</u>	\$ <u>22,085.08</u>
	TOTALS	\$ <u>401,389.74</u>	\$ <u>125,262.71</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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden North Shore Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

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 2000 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 2000.

(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>10-28-429-023-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,065.03</u>	\$ <u>22,065.03</u>
2. <u>10-28-429-024-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,048.27</u>	\$ <u>22,048.27</u>
3. <u>10-28-429-025-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,048.27</u>	\$ <u>22,048.27</u>
4. <u>10-28-429-026-0000</u>	<u>Nursing Home Facility</u>	\$ <u>22,048.27</u>	\$ <u>22,048.27</u>
5. <u>10-28-429-027-0000</u>	<u>Nursing Home Facility</u>	\$ <u>18,041.17</u>	\$ <u>18,041.17</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>106,251.01</u>	\$ <u>106,251.01</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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

Report Period Beginning:

1/1/07

Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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	<u>SNF</u>	<u>34,483</u>	<u>1997</u>	<u>\$ 955,797</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	34,483		\$ 955,797	3

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

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	Related party-Forum		1978	\$ 14,541	\$	25	\$	\$	\$ 14,541	4
5										5
6	93	1999	1999	6,782,967	203,542	40	169,574	(33,968)	1,356,592	6
7										7
8										8
	Improvement Type**									
9	draper corp-electric screen		1999	1,252	125	10	125		1,043	9
10	dakota wiring & comm.-wiring for cable tv		1999	2,500	250	10	250		2,063	10
11	climate serv-repair compressor		1999	1,990	133	15	133		1,072	11
12	fcj cable-install cable		1999	1,254	125	10	125		1,023	12
13	ABC-install tiles/repair		2000	4,011	267	15	267		2,094	13
14	ABC-mainten-various/construction		2000	5,000	500	10	500		3,917	14
15	ABC-mainten-various/construction		2000	10,000	1,000	10	1,000		7,750	15
16	ABC-mainten-various/construction		2000	10,000	1,000	10	1,000		7,667	16
17	new horizons-phone system		2000	5,744	574	10	574		4,451	17
18	new horizons-phone system & cable		2000	2,784	278	10	278		2,134	18
19	new horizons-phone system		2000	3,742	374	10	374		2,868	19
20	dfs contract.-lawn sprinkler system		2000	1,611	107	15	107		805	20
21	ABC-misc construction work		2000	5,347		5			5,347	21
22	ABC-misc construction work		2000	13,118		5			13,118	22
23	ABC-misc construction work (12/31/01 finished-begin exp '02)		2001	3,361	336	10	336		2,016	23
24	Laport (walk off mat carpet/floor covering)		2001	3,548		5			3,548	24
25	The Floor Source (PT carpet/floor covering)		2001	1,576		5			1,576	25
26	ABC-beds/bedside cabinets/washers/dryers/bookcases/wallcover		2001	289,721	19,315	15	19,315		135,204	26
27	New Horizon (phone system)		2001	1,256	126	10	126		775	27
28										28
29										29
30	ABC-misc construction work		2002	16,368	1,091	15	1,091		6,547	30
31	ABC-misc construction work		2003	2,116	212	10	212		1,059	31
32	GT Mechanical-repair exhaust fans		2003	6,080	608	10	608		2,837	32
33	EWS-repair opxyen alarm ssystem		2003	2,054	411	5	411		1,849	33
34	ABC-parking lot upgrades		2003	7,538	753	10	753		3,391	34
35	ABC-parking lot repairs		2003	2,943	589	5	589		2,650	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

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	GT Mechanical-thermostat equip	2004	\$ 1,693	\$ 169	10	\$ 169	\$	\$ 677	37
38	ABC-repair sewer	2004	19,580	1,958	10	1,958		7,343	38
39	GT Mechanical-misc repairs	2004	1,442	288	5	288		1,057	39
40	GT Mechanical-replace pump	2004	2,496	499	5	499		1,788	40
41	GT Mechanical-misc repairs	2004	614	123	5	123		441	41
42	ABC-bath,plumb. Upgrade	2004	1,813	181	10	181		649	42
43	ABC-painting supplies	2004	1,258	252	5	252		881	43
44	GT Mechanical-Electric improvement	2004	917	92	10	92		306	44
45	ABC-plumbing/misc. repairs	2004	3,971	397	10	397		1,290	45
46									46
47	TopNotch-motor drive repair	2004	3,139	314	10	314		968	47
48	ABD- carpet repairs	2004	4,943	494	10	494		1,524	48
49	ABC-misc repairs	2004	2,783	398	7	398		1,492	49
50	ABC parking lot improve.	2004	16,008	1,601	10	1,601		5,203	50
51									51
52	ABC-Cabinetry	2005	4,393	220	15	220		622	52
53	Patten CAT-Repair Generator	2005	2,074	104	20	104		285	53
54	GT Mechanical-No AC Water/Temp Low	2005	1,340	89	10	89		223	54
55	GT Mechanical-3 new motors, motor brackets, and fan blades	2005	4,497	187	10	187		600	55
56									56
57									57
58	seal/crack/fill asphalt (LLC)	2005	6,045	756	8	756		1,889	58
59	ABC-Patten Repair Generator	2006	2,898	217	10	217		217	59
60									60
61									61
62	Repaired AC	2006	7,776	778	10	778		972	62
63	Replace Domestic Water Pump	2007	3,032	51	10	51		51	63
64									64
65	Repair Water Heater	2007	3,237	297	10	297		297	65
66	New Motors/brackets/fan blades	2007	4,497	899	5	899		899	66
67	Replace/Repair Generator	2007	2,898	290	10	290		290	67
68	Second Floor Nurses Station	2007	4,246	617	10	617		425	68
69	Repair Condensor/Fan Motor sensors	2007	2,529	379	5	379		253	69
70	TOTAL (lines 4 thru 69)		\$ 7,312,539	\$ 243,365		\$ 209,397	\$ (33,968)	\$ 1,618,580	70

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,312,539	\$ 243,365		\$ 209,397	\$ (33,968)	\$ 1,618,580	1
2	Installed new alerton controlls/rewire/cycling relay	2005	7,064	706	10	706		1,766	2
3	tile and grout restoration-all ceramic tile floors	2005	7,830	483	10	483		1,957	3
4	replaced leaky ceiling parts	2005	1,480	296	5	296		740	4
5	fabricate/install elevator finishes/baseboards/etc.	2005	12,843	1,284	10	1,284		3,211	5
6	new hvac motor	2005	3,860	386	10	386		804	6
7	wired new electronic starter	2005	1,530	153	10	153		319	7
8	replaced domestic water pump-ABC	2007	3,032	304	10	304		51	8
9	replaced ambulance bollard-ABC	2007	1,924	400	4	400		40	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,352,102	\$ 247,377		\$ 213,409	\$ (33,968)	\$ 1,627,467	34

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

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

Report Period Beginning:

1/1/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,352,102	\$ 247,377		\$ 213,409	\$ (33,968)	\$ 1,627,467	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 Improvement-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)		\$ 7,432,200	\$ 250,187		\$ 216,219	\$ (33,968)	\$ 1,692,743	34

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

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

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	\$ 551,461	\$ 78,541	\$ 46,569	\$ (31,972)	Various	\$ 570,881	71
72	Current Year Purchases	8,512	1,124	1,124		Various	1,124	72
73	Fully Depreciated Assets	92,659	433	433		Various	92,659	73
74								74
75	TOTALS	\$ 652,632	\$ 80,098	\$ 48,126	\$ (31,972)		\$ 664,664	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)	\$ 9,040,747	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 330,314	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 264,374	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (65,940)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,357,525	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party-Cost is Backed out

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,840 Description: Copy Machine Lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19	<u>Related Party - AMS</u>	<u>Various</u>	<u>845.92</u>	<u>10,151</u>	19
20					20
21	TOTAL		\$ <u>845.92</u>	\$ <u>10,151</u>	21

10. Effective dates of current rental agreement:

Beginning 3/1/2000

Ending 12/31/2039

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

Fiscal Year Ending Annual Rent

12. /2008 \$ Varies

13. /2009 \$ Varies

14. /2010 \$ 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$		\$ 465,198	\$		\$ 465,198	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			26,012			26,012	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			800,781			800,781	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				519,763		519,763	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					170,916	138,287		309,203	13
14	TOTAL			\$		\$ 1,462,907	\$ 658,050		\$ 2,120,957	14

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

XIV. Special Services (Direct Cost)

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	\$465,198.18
2. ST	39-3	To Col 5	26,012.09
3.			
4. PT	39-3	To Col 5	800,781.22
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			350,428.52
Manual Input from Related Party- Forum Drugs			169,334.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	519,762.52
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	170,916.00
Other			467,756.18
Manual Input: Related Party - Prism			(44,565.00)
Manual Input: Related Party FECII - I.V.			(284,850.00)
Manual Input: Related Party FECII - Wound Care			(54.00)
Oxygen, from reclass worksheet			
13. Col 6: Supplies Total		To Col 6	138,287.18
13. Total Line 13, Column 8			309,203.18
14. Total			2,120,957.19

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

Report Period Beginning: 1/1/07

Ending:

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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	2	
		Operating	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>43,000</u>)	1,084,882	1,084,882	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		43,195	6
7	Other Prepaid Expenses	23,441	23,441	7
8	Accounts Receivable (owners or related parties)	140,602	3,035,341	8
9	Other(specify): <u>Due from 3rd Parties</u>	40,441	40,441	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,289,366	\$ 4,227,300	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		955,797	13
14	Buildings, at Historical Cost		7,878,133	14
15	Leasehold Improvements, at Historical Cost	488,334	548,111	15
16	Equipment, at Historical Cost	162,829	1,107,999	16
17	Accumulated Depreciation (book methods)	(372,157)	(2,536,745)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,343	26,343	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,343)	(26,343)	20
21	Restricted Funds		700,354	21
22	Other Long-Term Assets (spec <u>Escrow Ins,RE Tax</u>		187,724	22
23	Other(specify): <u>Refinance Fee, net</u>		256,231	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 279,006	\$ 9,097,603	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,568,372	\$ 13,324,904	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 655,750	\$ 629,517	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,613	81,613	28
29	Short-Term Notes Payable	1,109,343	1,212,531	29
30	Accrued Salaries Payable	335,479	335,479	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,096	15,096	31
32	Accrued Real Estate Taxes(Sch.IX-B)		235,300	32
33	Accrued Interest Payable	14,293	65,424	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accr Ins, Exps, IDPA, Sales Tax, Etc.</u>	9,232	9,232	36
37	<u>Deferred Revenue</u>		226,010	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,220,806	\$ 2,810,202	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,928,371	39
40	Mortgage Payable		8,171,700	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Shareholder Loan</u>	100,000	100,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$ 11,200,070	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,320,806	\$ 14,010,272	46
47	TOTAL EQUITY(page 18, line 24)	\$ (752,434)	\$ (685,368)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,568,372	\$ 13,324,904	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,065,631)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,065,631)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,313,197	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)	\$ 1,313,197	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)	\$ (752,434)	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	\$ 10,363,121	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,363,121	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,081	6
7	Oxygen	372	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 59,453	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	136	12
13	Barber and Beauty Care	(281)	13
14	Non-Patient Meals	149	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	14,251	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	681	19
20	Radiology and X-Ray		20
21	Other Medical Services	26,126	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 41,061	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,094	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,094	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income/ Meals	2,418	28
28a	Gain on Sale of Asset/Adjustment to prior year exp	31,994	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,412	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,500,141	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,395,584	31
32	Health Care	2,403,113	32
33	General Administration	1,872,243	33
	B. Capital Expense		
34	Ownership	1,354,606	34
	C. Ancillary Expense		
35	Special Cost Centers	2,110,480	35
36	Provider Participation Fee	50,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,186,944	40
41	Income before Income Taxes (line 30 minus line 40)**	1,313,197	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,313,197	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 North Shore Rehab & HCC

0042028

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	2,536	2,544	\$ 96,297	\$ 37.85	1
2	Assistant Director of Nursing	1,168	1,168	42,797	36.64	2
3	Registered Nurses	24,024	25,588	821,062	32.09	3
4	Licensed Practical Nurses	4,297	4,547	118,180	25.99	4
5	CNAs & Orderlies	52,891	54,865	766,791	13.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,080	2,080	28,447	13.68	8
9	Activity Director	2,048	2,080	36,588	17.59	9
10	Activity Assistants	3,378	3,802	39,312	10.34	10
11	Social Service Workers	1,986	2,078	40,338	19.41	11
12	Dietician					12
13	Food Service Supervisor	2,051	2,051	47,766	23.29	13
14	Head Cook	6,536	6,668	98,850	14.82	14
15	Cook Helpers/Assistants	30,417	32,177	353,356	10.98	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	53,871	25.90	17
18	Housekeepers	9,329	10,156	98,668	9.72	18
19	Laundry	6,175	6,642	60,538	9.11	19
20	Administrator	2,072	2,072	103,025	49.72	20
21	Assistant Administrator	2,768	2,800	73,541	26.26	21
22	Other Administrative	3,392	3,512	98,209	27.96	22
23	Office Manager	2,012	2,012	29,241	14.53	23
24	Clerical	2,669	2,769	22,786	8.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,397	2,397	79,072	32.99	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Unit Director	2,080	2,080	34,756	16.71	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,386	176,168	\$ 3,143,491 *	\$ 17.84	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	200/Monthly	\$ 2,400	1-3	35
36	Medical Director	9542/Monthly	114,500	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	186/Monthly	2,232	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	258/Monthly	3,096	11-3	44
45	Social Service Consultant	37/Monthly	448	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 122,676		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

Reporting Period Beginning

1/1/2007

Reporting Period Ending

12/31/2007

Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
	Balance Forward from PG 21	819,412.00
Kenneth Fisch	Legal Fees: Collections	15,064.00
ABC	Professional Fees	77.00
		<hr/> <hr/> 834,553.00

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	painting>\$1500 for 2000	7/00	\$ 2,176	3	\$ 363	\$ 0																		
2	GT Mechanical-repair ho	10/03	2,258	3	753	753	564	0	0															
3	ABC-repair water booster	6/03	2,209	3	736	736	308	0	0															
4																								
5																								
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17																								
18																								
19																								
20	TOTALS		\$ 6,643		\$ 1,852	\$ 1,489	\$ 872	\$	\$	\$	\$	\$	\$											

Facility Name & ID Number Alden North Shore Rehab & HCC

0042028

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Ending:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (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. \$ 4,056
- (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. \$ 19,812 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. \$ 50,918
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. \$ 30,024 Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: Reznick Group, LP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not required.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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