

		FOR BHF USE				

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

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047191

Facility Name: Alden Springs

Address: 207 East Army Trail Road Bloomington 60108
 Number City Zip Code

County: Dupage

Telephone Number: (630) 523-5783 **Fax #** (630)523-5787

HFS ID Number: 83-0375144

Date of Initial License for Current Owners: 9/25/06

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

Facility Name & ID Number Alden Springs# 0047191 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>4,240</u>			<u>4,240</u>
14	TOTALS	<u>4,240</u>			<u>4,240</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.60%

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

334 (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/AF. Does the facility maintain a daily midnight census? Yes

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

YES NO

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

YES NO

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

Date started 10/13/06

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____Medicare Intermediary N/A

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 Springs # 0047191 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	41,842	884		42,726	21	42,747	492	43,239		1
2	Food Purchase		45,185		45,185	(2,208)	42,977	(15,323)	27,654		2
3	Housekeeping	1,594	12,694		14,288	358	14,646	343	14,989		3
4	Laundry	1,594	1,386		2,980		2,980		2,980		4
5	Heat and Other Utilities			21,150	21,150		21,150	(21)	21,129		5
6	Maintenance	2,782		34,257	37,039		37,039	1,000	38,039		6
7	Other (specify):* Rel Party Benef							690	690		7
8	TOTAL General Services	47,812	60,149	55,407	163,368	(1,829)	161,539	(12,819)	148,720		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	363,943	18,074	764	382,781	336	383,117	4,249	387,366		10
10a	Therapy					6,045	6,045	(4,301)	1,744		10a
11	Activities			20,949	20,949		20,949		20,949		11
12	Social Services	31,316			31,316		31,316		31,316		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Rel Party Benef							725	725		15
16	TOTAL Health Care and Programs	395,259	18,074	24,713	438,046	6,381	444,427	673	445,100		16
	C. General Administration										
17	Administrative							29,679	29,679		17
18	Directors Fees										18
19	Professional Services			59,737	59,737		59,737	(51,057)	8,680		19
20	Dues, Fees, Subscriptions & Promotions			4,411	4,411		4,411	(3,133)	1,278		20
21	Clerical & General Office Expenses	8,543	4,709	13,693	26,945		26,945	20,255	47,200		21
22	Employee Benefits & Payroll Taxes			62,947	62,947	1,493	64,440		64,440		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,502	2,502		2,502	258	2,760		24
25	Other Admin. Staff Transportation							1,026	1,026		25
26	Insurance-Prop.Liab.Malpractice			16,039	16,039	(73)	15,966	2,276	18,242		26
27	Other (specify):* Rel Party Benef			19,913	19,913		19,913	(15,196)	4,717		27
28	TOTAL General Administration	8,543	4,709	179,242	192,494	1,420	193,914	(15,892)	178,022		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	451,614	82,932	259,362	793,908	5,972	799,880	(28,038)	771,842		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 Springs #0047191 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			1,916	1,916		1,916	62,577	64,493		30
31	Amortization of Pre-Op. & Org.							6	6		31
32	Interest			328	328	73	401	96,511	96,912		32
33	Real Estate Taxes							5,794	5,794		33
34	Rent-Facility & Grounds			128,904	128,904		128,904	(128,904)			34
35	Rent-Equipment & Vehicles			3,965	3,965		3,965	3,102	7,067		35
36	Other (specify):*										36
37	TOTAL Ownership			135,113	135,113	73	135,186	39,086	174,272		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		10,442	6,121	16,563	(6,045)	10,518	(3,762)	6,756		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			56,566	56,566		56,566		56,566		42
43	Other (specify):* Day Training			70,016	70,016		70,016		70,016		43
44	TOTAL Special Cost Centers		10,442	132,703	143,145	(6,045)	137,100	(3,762)	133,338		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	451,614	93,374	527,178	1,072,166		1,072,166	7,286	1,079,452		45

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

Input official Company Name from Pg 1

Reporting Period Beginning

Reporting Period Ending

IDPH Facility ID Number:

Page 4A

Reclassifications - Pgs 3 and 4

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(2,208.00)	Employee Meals
	22	2,208.00	Employee Meals
39		(6,045.00)	PT/OT/ST- DD Therapies to Ln 10a
	10A	6,045.00	PT/OT/ST- DD Therapies to Ln 10a
26		(73.00)	Insurance Expense
	32	73.00	Insurance Expense
22		(715.00)	Employee Uniforms
	1	21.00	
	3	358.00	
	4		
	6		
	10	336.00	
	11		
	21		
<hr/>			
			-

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning: 1/1/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,789)	21		17
18	Fines and Penalties	(328)	32		18
19	Entertainment				19
20	Contributions	(306)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(45)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,914)	27		24
25	Fund Raising, Advertising and Promotional	(2,857)	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)	\$ (27,239)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	36,189	Various	34
35	Other- Attach Schedule	(1,664)	PG 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 34,525		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 7,286		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Alden Springs

ID# 0047191
 Report Period Beginning: 1/1/07
 Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (265)	5	1
2	Back out 29.31% (for 2007) of PAC fees	(259)	20	2
3	Reduce deprec exp on Pg 13 items under \$2500	(2,876)	30	3
4	Reduce deprec exp on Pg 12 items under \$2500	(42)	30	4
5	Expense capital items > \$2500 on Pg 13 items	852	6	5
6	Expense capital items > \$2500 on Pg 12 items	840	6	6
7	Elim. Bank Charges on LLC	(5)	19	7
8	To correct depr to actual	29	30	8
9	Leadership Training Adjustment	62	24	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				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	(1,664)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	492	0	0	0	0	0	0	0	0	492	1
2	Food Purchase	0	0	0	(15,323)	0	0	0	0	0	0	0	(15,323)	2
3	Housekeeping	0	0	343	0	0	0	0	0	0	0	0	343	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(265)	0	244	0	0	0	0	0	0	0	0	(21)	5
6	Maintenance	1,692	0	(596)	0	0	0	(96)	0	0	0	0	1,000	6
7	Other (specify):*	0	0	550	140	0	0	0	0	0	0	0	690	7
8	TOTAL General Services	1,427	0	1,033	(15,183)	0	0	(96)	0	0	0	0	(12,819)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,156	0	93	0	0	0	0	0	0	4,249	10
10a	Therapy	0	0	0	0	0	(4,301)	0	0	0	0	0	(4,301)	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	725	0	0	0	0	0	0	0	0	725	15
16	TOTAL Health Care and Programs	0	0	4,881	0	93	(4,301)	0	0	0	0	0	673	16
	C. General Administration													
17	Administrative	0	0	29,679	0	0	0	0	0	0	0	0	29,679	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(50)	5	(51,012)	0	0	0	0	0	0	0	0	(51,057)	19
20	Fees, Subscriptions & Promotions	(3,422)	247	42	0	0	0	0	0	0	0	0	(3,133)	20
21	Clerical & General Office Expenses	(3,789)	0	20,623	3,119	302	0	0	0	0	0	0	20,255	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	62	0	196	0	0	0	0	0	0	0	0	258	24
25	Other Admin. Staff Transportation	0	0	1,026	0	0	0	0	0	0	0	0	1,026	25
26	Insurance-Prop.Liab.Malpractice	0	2,258	18	0	0	0	0	0	0	0	0	2,276	26
27	Other (specify):*	(19,914)	0	4,569	291	(142)	0	0	0	0	0	0	(15,196)	27
28	TOTAL General Administration	(27,113)	2,510	5,141	3,410	160	0	0	0	0	0	0	(15,892)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,686)	2,510	11,055	(11,773)	253	(4,301)	(96)	0	0	0	0	(28,038)	29

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

1/1/07

Ending:

Summary B

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,889)	60,713	3,226	0	1,527	0	0	0	0	0	0	62,577	30
31	Amortization of Pre-Op. & Org.	0	0	6	0	0	0	0	0	0	0	0	6	31
32	Interest	(328)	85,909	10,911	0	17	2	0	0	0	0	0	96,511	32
33	Real Estate Taxes	0	5,413	375	0	6	0	0	0	0	0	0	5,794	33
34	Rent-Facility & Grounds	0	(128,904)	0	0	0	0	0	0	0	0	0	(128,904)	34
35	Rent-Equipment & Vehicles	0	0	3,102	0	0	0	0	0	0	0	0	3,102	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,217)	23,131	17,620	0	1,550	2	0	0	0	0	0	39,086	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	(4,054)	292	0	0	0	0	0	0	(3,762)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(4,054)	292	0	0	0	0	0	0	(3,762)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(28,903)	25,641	28,675	(15,827)	2,095	(4,299)	(96)	0	0	0	0	7,286	45

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

1/1/07

Ending:

12/31/07

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Income	\$ 128,904	Alden Trails II, LLC	100.00%	\$	\$ (128,904)	1
2	V	20 Miscellaneous Income	3	Alden Trails II, LLC			(3)	2
3	V	19 Bank Charges		Alden Trails II, LLC		5	5	3
4	V	20 Dues & Subscriptions		Alden Trails II, LLC		250	250	4
5	V	33 Real Estate Tax Exp		Alden Trails II, LLC		5,413	5,413	5
6	V	26 General Insurance Exp		Alden Trails II, LLC		2,258	2,258	6
7	V	32 Interest Harris		Alden Trails II, LLC		85,909	85,909	7
8	V	30 Depreciation Expense		Alden Trails II, LLC		60,713	60,713	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 128,907			\$ 154,548	\$ * 25,641	14

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

Facility Name & ID Number Alden Springs# 0047191Report Period Beginning: 1/1/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	5	Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 244	\$ 244	15	
16	V	24	Trav & Seminar		Alden Management Services, Inc.		196	196	16	
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,026	1,026	17	
18	V	26	Insurance		Alden Management Services, Inc.		18	18	18	
19	V	20	Dues & Subscriptions		Alden Management Services, Inc.		42	42	19	
20	V	30	Depreciation		Alden Management Services, Inc.		3,226	3,226	20	
21	V	31	Amortization		Alden Management Services, Inc.		6	6	21	
22	V	33	Real Estate Tax		Alden Management Services, Inc.		375	375	22	
23	V	35	Rent-Equip & Vehicles		Alden Management Services, Inc.		3,102	3,102	23	
24	V	32	Interest		Alden Management Services, Inc.		10,911	10,911	24	
25	V	1	Dietary		Alden Management Services, Inc.		492	492	25	
26	V	3	Housekeeping		Alden Management Services, Inc.		343	343	26	
27	V	7	Employee Benefits-Gen'l Servs		Alden Management Services, Inc.		550	550	27	
28	V	10	Nurs & Med Records Salary		Alden Management Services, Inc.		4,156	4,156	28	
29	V	15	Employee Benefits-Health Care		Alden Management Services, Inc.		725	725	29	
30	V	17	Administrative Salary		Alden Management Services, Inc.		29,679	29,679	30	
31	V								31	
32	V	27	Employee Benefits-Admin		Alden Management Services, Inc.		4,569	4,569	32	
33	V	19	Professional Fees	54,722	Alden Management Services, Inc.		3,710	(51,012)	33	
34	V	21	Gen'l & Admin		Alden Management Services, Inc.		20,623	20,623	34	
35	V	6	Repair & Maint	3,737	Alden Management Services, Inc.		3,141	(596)	35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 58,459			\$ 87,134	\$ *	28,675	39

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

Facility Name & ID Number Alden Springs# 0047191Report Period Beginning: 1/1/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	Diet. Consultant	\$	Prism Health Care Services, Inc.	0.00%	\$	\$	15
16	V	1	Dietary Salary		Prism Health Care Services, Inc.				16
17	V	2	Tube Feeding	20,853	Prism Health Care Services, Inc.		5,530	(15,323)	17
18	V	10	Equip Rental		Prism Health Care Services, Inc.				18
19	V	39	Ancillary Supplies	7,836	Prism Health Care Services, Inc.		3,782	(4,054)	19
20	V	21	Gen'l & Admin Salary		Prism Health Care Services, Inc.		1,241	1,241	20
21	V	27	Employee Benefits		Prism Health Care Services, Inc.		291	291	21
22	V	7	Employee Benefits		Prism Health Care Services, Inc.		140	140	22
23	V	21	Gen'l & Admin		Prism Health Care Services, Inc.		1,878	1,878	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		\$ 28,689				\$ 12,862	\$ * (15,827)	39

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

Facility Name & ID Number Alden Springs# 0047191Report Period Beginning: 1/1/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39	Drugs	\$ 1,201	Forum Extended Care Services II, Inc.	0.00%	\$ 1,781	\$ 580	15
16	V	39	IV		Forum Extended Care Services II, Inc.				16
17	V	39	Wound Care	1,404	Forum Extended Care Services II, Inc.		1,116	(288)	17
18	V	10	House Stock	857	Forum Extended Care Services II, Inc.		818	(39)	18
19	V	10	Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		516	132	19
20	V	27	Employee Vaccin.	755	Forum Extended Care Services II, Inc.		592	(163)	20
21	V	27	Employee Benefits: G&A		Forum Extended Care Services II, Inc.		21	21	21
22	V	21	Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		162	162	22
23	V	21	Gen'l & Admin		Forum Extended Care Services II, Inc.		140	140	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		17	17	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		6	6	25
26	V	30	Depreciation		Forum Extended Care Services II, Inc.		1,527	1,527	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 4,601				\$ 6,696	\$ * 2,095	39

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

Facility Name & ID Number Alden Springs# 0047191Report Period Beginning: 1/1/07Ending: 12/31/07**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Therapy	\$ 6,045	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,744	\$ (4,301)	15
16	V	32	Interest				2	2	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			\$ 6,045			\$ 1,746	\$ *	(4,299) 39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$ 7,049	Alden Bennett Construction Company, Inc.	0.00%	\$ 6,953	\$ (96)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 7,049			\$ 6,953	\$ *	(96) 39

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

STATE OF ILLINIOS

Facility Name & ID Number

Alden Springs, Inc

Provider No.

004-7191

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 Springs # 0047191 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	170,372	0.148	0.00	Salary	\$ 628	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	64,243	0.148	0.00	Salary	237	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	37,821	0.148	0.00	Salary	139	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	\$ 1,004		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 Springs

0047191

Report Period Beginning:

1/1/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,154,703	29	\$ 66,329	\$ 4,240	\$ 244	1
2	24	Trav & Seminar	Patient Days	1,154,703	29	53,403	4,240	196	2
3	25	Other Admin Travel	Patient Days	1,154,703	29	279,431	4,240	1,026	3
4	26	Insurance	Patient Days	1,154,703	29	4,925	4,240	18	4
5	20	Dues & Subscriptions	Patient Days	1,154,703	29	11,328	4,240	42	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	4,240	6	7
8	33	Real Estate Tax	Patient Days/usage	1,154,703	29	102,244	4,240	375	8
9	35	Rent-Equip & Vehicles	Patient Days	1,154,703	29	844,835	4,240	3,102	9
10	32	Interest	Patient Days/usage	1,154,703	29	2,971,454	4,240	10,911	10
11	1	Dietary	Patient Days	1,154,703	29	133,965	133,965	492	11
12	3	Housekeeping	Patient Days	1,154,703	29	93,421	93,421	343	12
13	7	Employee Benefits-Gen'l Servs	Patient Days	1,154,703	29	149,914	4,240	550	13
14	10	Nurs & Med Records Salary	Patient Days	1,154,703	29	1,131,827	1,178,420	4,156	14
15	15	Employee Benefits-Health Care	Patient Days	1,154,703	29	197,574	4,240	725	15
16	17	Administrative Salary	Patient Days/usage	1,154,703	29	8,082,649	1,091,420	29,679	16
17									17
18	27	Employee Benefits-Admin	Patient Days	1,154,703	29	1,244,181	4,240	4,569	18
19	19	Professional Fees	Patient Days	1,154,703	29	1,010,272	531,592	3,710	19
20	21	Gen'l & Admin	Patient Days	1,154,703	29	5,616,348	4,942,836	20,623	20
21	6	Repair & Maint	Patient Days	1,154,703	29	855,298	666,770	3,141	21
22									22
23									23
24									24
25	TOTALS					\$ 22,944,452	\$ 8,638,424	\$ 87,134	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	Harris		x	Mortgage	\$10,752.46	12/1/06	\$ 1,781,000	\$ 1,745,932	11/01/2011	5.2500	\$ 85,909	1								
2												2								
3												3								
4												4								
5	Insurance Interest-see reclass		x								73	5								
Working Capital																				
6	Related Party - CPT										2	6								
7	Related Party - AMS										10,911	7								
8	Related Party - FECII										17	8								
9	TOTAL Facility Related				\$10,752.46		\$ 1,781,000	\$ 1,745,932			\$ 96,912	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,781,000	\$ 1,745,932			\$ 96,912	15								

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

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 Springs COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0047191

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>See Attached (12 Pg Supplement)</u>	<u>Related Party-Alden Management Serv</u>	\$ <u>241,399.00</u>	\$ <u>375.00</u>
2. <u>See Attached (12 Pg Supplement)</u>	<u>Related Party-Forum Professional Cen</u>	\$ <u>37,806.00</u>	\$ <u>6.00</u>
3. <u>02-23-300-024</u>	<u>Nursing Home Facility</u>	\$ <u>3,631.64</u>	\$ <u>3,631.64</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>282,836.64</u>	\$ <u>4,012.64</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 Springs

0047191

Report Period Beginning:

1/1/07

Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,150 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories One

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>22,035</u>		<u>\$ 398,630</u>	1
2					2
3	TOTALS	22,035		\$ 398,630	3

Facility Name & ID Number Alden Springs

0047191

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			2006	\$ 1,583,599	\$ 39,590	40	\$ 39,590		\$ 49,487	4
5				2006	69,510	1,738	40	1,738		2,172	5
6				2006	20,156	504	40	504		840	6
7											7
8		Related Party-Forum		1978	14,541		25			14,541	8
		Improvement Type**									
9		Plumb, Floor Prep, Fencing-ABC Renovation		2007	23,127	2,313	40	2,313		2,313	9
10		Wiring		2006	840	42	20	42		53	10
11		Drywall Carpentry		2007	18,677	830	15	830		830	11
12											12
13											13
14											14
15											15
16											16
17											17
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35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Springs

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,730,451	\$ 45,016		\$ 45,016	\$	\$ 70,236	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		914	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)		\$ 1,810,550	\$ 47,827		\$ 47,827	\$	\$ 135,583	34

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

Facility Name & ID Number Alden Springs # 0047191 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	\$ 164,686	\$ 16,351	\$ 16,351	\$		\$ 29,519	71
72	Current Year Purchases	212	14	14			14	72
73	Fully Depreciated Assets	67,358	271	271			67,358	73
74								74
75	TOTALS	\$ 232,256	\$ 16,636	\$ 16,636	\$		\$ 96,891	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)	\$ 2,441,553	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,493	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,493	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)	\$ 232,591	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party, cost is backed out

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning 1/1/07

Ending 11/1/2011

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

Fiscal Year Ending Annual Rent

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,965 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>147.25</u>	<u>1,767</u>	19
20					20
21	TOTAL		\$ <u>147.25</u>	\$ <u>1,767</u>	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled Nursing on site</u></p>	<p>2. 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.

Facility Name & ID Number Alden Springs# 0047191 Report Period Beginning:

1/1/07

Ending:

12/31/07

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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescripts				1,781		1,781	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						4,975		4,975	13
14	TOTAL			\$		\$	\$ 6,756		\$ 6,756	14

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

XIV. Special Services (Direct Cost)

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

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	Col. No.
1. OT	39-3	To Col 5	
2. ST	39-3	To Col 5	
3.			
4. PT	39-3	To Col 5	
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			1,200.96
Manual Input from Related Party- Forum Drugs			580.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	1,780.96
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	
Other			9,316.80
Manual Input: Related Party - Prism			(4,054.00)
Manual Input: Related Party Wound Care			(289.00)
13. Col 6: Supplies Total		To Col 6	4,973.80
13. Total Line 13, Column 8			0.00
14. Total			6,754.76

Facility Name & ID Number Alden Springs # 0047191 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>1,200</u>)	511,644	511,644	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		1,909	6
7	Other Prepaid Expenses	2,994	2,994	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 514,638	\$ 516,547	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		398,630	13
14	Buildings, at Historical Cost		1,673,266	14
15	Leasehold Improvements, at Historical Cost	18,677	19,517	15
16	Equipment, at Historical Cost	6,130	191,279	16
17	Accumulated Depreciation (book methods)	(2,248)	(77,390)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,559	\$ 2,205,302	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 537,197	\$ 2,721,849	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,748	\$ 168,783	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,697	2,697	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,876	35,876	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,300	3,300	31
32	Accrued Real Estate Taxes(Sch.IX-B)		3,800	32
33	Accrued Interest Payable			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>	1,082	1,082	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 118,703	\$ 215,538	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,745,932	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Affiliates</u>	718,023	650,507	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 718,023	\$ 2,396,439	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 836,726	\$ 2,611,977	46
47	TOTAL EQUITY(page 18, line 24)	\$ (299,529)	\$ 109,872	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 537,197	\$ 2,721,849	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4	Bad Debt, Medicare revenues (non allowables)	(69,783)	4
5	Adjustments (Late) to Prior Year Balances		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (69,783)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(229,746)	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)	\$ (229,746)	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)	\$ (299,529)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning: 1/1/07

Ending: 12/31/07

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 772,404	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 772,404	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Income	70,016	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 70,016	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 842,420	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	163,368	31
32	Health Care	438,046	32
33	General Administration	192,494	33
B. Capital Expense			
34	Ownership	135,113	34
C. Ancillary Expense			
35	Special Cost Centers	86,579	35
36	Provider Participation Fee	56,566	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,072,166	40
41	Income before Income Taxes (line 30 minus line 40)**	(229,746)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (229,746)	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 Springs

0047191

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing				1	
2	Assistant Director of Nursing				2	
3	Registered Nurses				3	
4	Licensed Practical Nurses	5,671	5,765	145,738	25.28	4
5	CNAs & Orderlies				5	
6	CNA Trainees				6	
7	Licensed Therapist				7	
8	Rehab/Therapy Aides				8	
9	Activity Director				9	
10	Activity Assistants				10	
11	Social Service Workers				11	
12	Dietician				12	
13	Food Service Supervisor	130	130	2,419	18.61	13
14	Head Cook	3,312	3,332	39,091	11.73	14
15	Cook Helpers/Assistants	29	29	332	11.45	15
16	Dishwashers					16
17	Maintenance Workers	130	130	2,782	21.40	17
18	Housekeepers	65	65	1,594	24.52	18
19	Laundry	65	65	1,594	24.52	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	258	260	8,543	32.86	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,040	2,040	31,316	15.35	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	18,750	19,202	218,205	11.36	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	30,450	31,018	\$ 451,614 *	\$ 14.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly		35	
36	Medical Director	Monthly	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	380	20,309		44
45	Social Service Consultant	10	640		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	390	\$ 24,333		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number Alden Springs

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. Il. Health Care Assoc. \$109
- (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. \$ 3,822 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. \$ 56,566
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,208 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not required.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.