

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

0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

III. STATISTICAL DATA

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

| | 1 | 2 | 3 | 4 | |
|---|------------------------------------|-----------------------------|------------------------------|--|---|
| | Beds at Beginning of Report Period | Licensure Level of Care | Beds at End of Report Period | Licensed Bed Days During Report Period | |
| 1 | 96 | Skilled (SNF) | 96 | 35,136 | 1 |
| 2 | | Skilled Pediatric (SNF/PED) | | 0 | 2 |
| 3 | | Intermediate (ICF) | | 0 | 3 |
| 4 | | Intermediate/DD | | 0 | 4 |
| 5 | | Sheltered Care (SC) | | 0 | 5 |
| 6 | | ICF/DD 16 or Less | | 0 | 6 |
| 7 | 96 | TOTALS | 96 | 35,136 | 7 |

B. Census-For the entire report period.

| | 1 Level of Care | 3 Patient Days by Level of Care and Primary Source of Payment | | | | 5 |
|----|--------------------|--|-------|------------|--------|----|
| | | 2 Medicaid Recipient | | 4 Other | Total | |
| | | Private Pay | | | | |
| 8 | SNF | 4,791 | 1,355 | 4,224 | 10,370 | 8 |
| 9 | SNF/PED | | | | | 9 |
| 10 | ICF | 14,188 | 3,293 | 14 | 17,495 | 10 |
| 11 | ICF/DD | | | | | 11 |
| 12 | SC | | | | | 12 |
| 13 | DD 16 OR LESS | | | | | 13 |
| 14 | TOTALS | 18,979 | 4,648 | 4,238 | 27,865 | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.31%

D. How many bed-hold days during this year were paid by the Department? none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) none

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 03/01/95

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 33 and days of care provided 3,487

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

| | Operating Expenses | Costs Per General Ledger | | | | Reclassification 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 | 213,631 | 13,399 | 10,800 | 237,830 | 874 | 238,704 | 1,447 | 240,151 | | 1 |
| 2 | Food Purchase | | 187,588 | | 187,588 | (21,304) | 166,284 | (31,949) | 134,335 | | 2 |
| 3 | Housekeeping | 98,699 | 27,261 | | 125,960 | 276 | 126,236 | 2,246 | 128,482 | | 3 |
| 4 | Laundry | 58,879 | 10,001 | | 68,880 | 333 | 69,213 | | 69,213 | | 4 |
| 5 | Heat and Other Utilities | | | 135,278 | 135,278 | | 135,278 | 17 | 135,295 | | 5 |
| 6 | Maintenance | 60,940 | | 117,391 | 178,331 | 115 | 178,446 | 17,434 | 195,880 | | 6 |
| 7 | Other (specify):* Related Party Benefits | | | | | | | 3,649 | 3,649 | | 7 |
| 8 | TOTAL General Services | 432,149 | 238,249 | 263,469 | 933,867 | (19,706) | 914,161 | (7,156) | 907,005 | | 8 |
| B. Health Care and Programs | | | | | | | | | | | |
| 9 | Medical Director | | | 33,300 | 33,300 | | 33,300 | | 33,300 | | 9 |
| 10 | Nursing and Medical Records | 1,383,836 | 134,894 | 2,448 | 1,521,178 | (25,770) | 1,495,408 | 72,451 | 1,567,859 | | 10 |
| 10a | Therapy | 31,397 | | | 31,397 | | 31,397 | | 31,397 | | 10a |
| 11 | Activities | 52,582 | 1,454 | 4,843 | 58,879 | 73 | 58,952 | | 58,952 | | 11 |
| 12 | Social Services | 38,638 | | | 38,638 | | 38,638 | | 38,638 | | 12 |
| 13 | CNA Training | | | | | | | | | | 13 |
| 14 | Program Transportation | | | | | | | | | | 14 |
| 15 | Other (specify):* Related Party Benefits | | | | | | | 4,318 | 4,318 | | 15 |
| 16 | TOTAL Health Care and Programs | 1,506,453 | 136,348 | 40,591 | 1,683,392 | (25,697) | 1,657,695 | 76,769 | 1,734,464 | | 16 |
| C. General Administration | | | | | | | | | | | |
| 17 | Administrative | 85,467 | | | 85,467 | | 85,467 | 43,345 | 128,812 | | 17 |
| 18 | Directors Fees | | | | | | | | | | 18 |
| 19 | Professional Services | | | 396,574 | 396,574 | (13,460) | 383,114 | (344,108) | 39,006 | | 19 |
| 20 | Dues, Fees, Subscriptions & Promotions | | | 48,226 | 48,226 | | 48,226 | (41,776) | 6,450 | | 20 |
| 21 | Clerical & General Office Expenses | 72,282 | 17,096 | 36,279 | 125,657 | 264 | 125,921 | 157,744 | 283,665 | | 21 |
| 22 | Employee Benefits & Payroll Taxes | | | 317,673 | 317,673 | 16,472 | 334,145 | | 334,145 | | 22 |
| 23 | Inservice Training & Education | | | | | | | | | | 23 |
| 24 | Travel and Seminar | | | 7,860 | 7,860 | | 7,860 | 1,387 | 9,247 | | 24 |
| 25 | Other Admin. Staff Transportation | | | 109 | 109 | | 109 | 6,747 | 6,856 | | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | | | 111,190 | 111,190 | (1,867) | 109,323 | 111 | 109,434 | | 26 |
| 27 | Other (specify):* Bad Debt & Related Party Benefits | | | 137,296 | 137,296 | | 137,296 | (107,988) | 29,308 | | 27 |
| 28 | TOTAL General Administration | 157,749 | 17,096 | 1,055,207 | 1,230,052 | 1,409 | 1,231,461 | (284,538) | 946,923 | | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8, 16 & 28) | 2,096,351 | 391,693 | 1,359,267 | 3,847,311 | (43,994) | 3,803,317 | (214,925) | 3,588,392 | | 29 |

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

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

V. COST CENTER EXPENSES (continued)

| | Capital Expense | Cost Per General Ledger | | | | Reclass-ification 5 | Reclassified Total 6 | Adjust-ments 7 | Adjusted Total 8 | FOR BHF USE ONLY | | |
|----|---|-------------------------|---------------|------------|------------|------------------------|----------------------------|-------------------|------------------------|------------------|----|----|
| | | Salary/Wage 1 | Supplies 2 | Other 3 | Total 4 | | | | | 9 | 10 | |
| | D. Ownership | | | | | | | | | | | |
| 30 | Depreciation | | | 40,640 | 40,640 | | 40,640 | (51) | 40,589 | | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | | | | | | | | | 31 |
| 32 | Interest | | | 39,122 | 39,122 | 1,867 | 40,989 | 15,761 | 56,750 | | | 32 |
| 33 | Real Estate Taxes | | | 135,040 | 135,040 | | 135,040 | (26,247) | 108,793 | | | 33 |
| 34 | Rent-Facility & Grounds | | | 529,425 | 529,425 | | 529,425 | | 529,425 | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 6,003 | 6,003 | | 6,003 | 21,141 | 27,144 | | | 35 |
| 36 | Other (specify):* | | | | | | | | | | | 36 |
| 37 | TOTAL Ownership | | | 750,230 | 750,230 | 1,867 | 752,097 | 10,604 | 762,701 | | | 37 |
| | Ancillary Expense | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | | | | | | | | | | | 38 |
| 39 | Ancillary Service Centers | | 274,284 | 304,607 | 578,891 | 42,127 | 621,018 | (116,667) | 504,351 | | | 39 |
| 40 | Barber and Beauty Shops | | | | | | | | | | | 40 |
| 41 | Coffee and Gift Shops | | | | | | | | | | | 41 |
| 42 | Provider Participation Fee | | | 52,704 | 52,704 | | 52,704 | | 52,704 | | | 42 |
| 43 | Other (specify):* | | | | | | | | | | | 43 |
| 44 | TOTAL Special Cost Centers | | 274,284 | 357,311 | 631,595 | 42,127 | 673,722 | (116,667) | 557,055 | | | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 2,096,351 | 665,977 | 2,466,808 | 5,229,136 | | 5,229,136 | (320,988) | 4,908,148 | | | 45 |

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

Alden Lincoln Rehab & Health Care Center

IDPH Facility ID Number: #0040709

Reclassifications on Pgs 3 & 4 - Column 5

Report Period Beginning: 1/1/2008

Report Period Ending: 12/31/2008

| <u>From Line</u> | <u>To Line</u> | <u>Amount</u> | <u>Description</u> |
|------------------------|----------------|---------------|---|
| 2 | | (21,304.00) | Employee Meals |
| | 22 | 21,304.00 | Employee Meals |
| 22 | | (4,832.00) | Uniforms |
| | 10 | 2,897.00 | Uniforms |
| | 1 | 874.00 | Uniforms |
| | 3 | 276.00 | Uniforms |
| | 4 | 333.00 | Uniforms |
| | 6 | 115.00 | Uniforms |
| | 11 | 73.00 | Uniforms |
| | 21 | 264.00 | Uniforms |
| 26 | | (831.00) | Interest - old policy/curr yr portion |
| | 32 | 831.00 | Interest - old policy/curr yr portion |
| 10 | | (42,127.00) | Oxygen - to appropriate cost center |
| | 39 | 42,127.00 | Oxygen - to appropriate cost center |
| <u>Others, if any:</u> | | | |
| 19 | | (13,460.00) | Reclass Clinical Coordinators (Pathways) to Ln 10 |
| | 10 | 13,460.00 | Reclass Clinical Coordinators (Pathways) to Ln 10 |

Net

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

0040709

Report Period Beginning: 1/1/08

Ending: 12/31/08

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 | (898) | 32 | | 10 |
| 11 | Discounts, Allowances, Rebates & Refunds | | | | 11 |
| 12 | Non-Working Officer's or Owner's Salary | | | | 12 |
| 13 | Sales Tax | (1,114) | 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 | 211 | 21 | | 17 |
| 18 | Fines and Penalties | (800) | 32 | | 18 |
| 19 | Entertainment | (584) | 20 | | 19 |
| 20 | Contributions | (5,142) | 20 | | 20 |
| 21 | Owner or Key-Man Insurance | | | | 21 |
| 22 | Special Legal Fees & Legal Retainers | (12,243) | 19 | | 22 |
| 23 | Malpractice Insurance for Individuals | | | | 23 |
| 24 | Bad Debt | (137,296) | 27 | | 24 |
| 25 | Fund Raising, Advertising and Promotional | (8,427) | 20 | | 25 |
| 26 | Income Taxes and Illinois Personal | | | | 26 |
| 27 | Property Replacement Tax | | | | 27 |
| 28 | CNA Training for Non-Employees | | | | 28 |
| 29 | Yellow Page Advertising | | | | 29 |
| 29 | Other-Attach Schedule | | | | 29 |
| 30 | SUBTOTAL (A): (Sum of lines 1-29) | \$ (166,293) | | \$ | 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) | (69,933) | Various | 34 |
| 35 | Other- Attach Schedule | (84,762) | PG 5A | 35 |
| 36 | SUBTOTAL (B): (sum of lines 31-35) | \$ (154,695) | | 36 |
| | (sum of SUBTOTALS | | | |
| 37 | TOTAL ADJUSTMENTS (A) and (B)) | \$ (320,988) | | 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 | | | x | | | 44 |
| 45 | Other-Attach Schedule | | x | | | 45 |
| 46 | Other-Attach Schedule | | x | | | 46 |
| 47 | TOTAL (C): (sum of lines 38-46) | | | \$ | | 47 |

Alden Lincoln Rehab & Health Care Center

ID# 0040709

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line

| NON-ALLOWABLE EXPENSES | | Amount | Reference | |
|------------------------|--|------------|-----------|----|
| 1 | Late Fees on Utilities | \$ (1,673) | 5 | 1 |
| 2 | Intercompany Interest | (38,322) | 32 | 2 |
| 3 | Misc Income (legal fees interest) | (8,762) | 21 | 3 |
| 4 | Misc Income (general) | (325) | 6 | 4 |
| 5 | Misc Income (medical records) | (95) | 10 | 5 |
| 6 | Misc Income (jury duty) | (34) | 21 | 6 |
| 7 | Misc Income (vending machine) | (326) | 2 | 7 |
| 8 | Misc Income (food rebate) | (143) | 2 | 8 |
| 9 | Misc Income (polling site) | (275) | 6 | 9 |
| 10 | back out IHCA PAC Fees 2008 - 32.30% | (1,595) | 20 | 10 |
| 11 | Deming Leadership Training adjustment | (578) | 24 | 11 |
| 12 | Add back pror year tax refund | 1,430 | 33 | 12 |
| 13 | back out Lincoln Park Chamber of Commerce dues | (550) | 20 | 13 |
| 14 | reduce depreciation exp on pg 13<\$2,500 | (3,848) | 30 | 14 |
| 15 | reduce depreciation exp on pg 12<\$2,500 | (1,266) | 30 | 15 |
| 16 | expense capital items >\$2,500 on pg 13 | 12,905 | 6 | 16 |
| 17 | expense capital items >\$2,500 on pg 12 | 6,290 | 6 | 17 |
| 18 | depreciation adjustment | 886 | 30 | 18 |
| 19 | Deferred maintenance adjustment | (1,678) | 6 | 19 |
| 20 | adj Real Estate Tax expense | (30,281) | 33 | 20 |
| 21 | back out Lake View East Chamber | (350) | 20 | 21 |
| 22 | back out Census Solution - Marketing | (22,500) | 19 | 22 |
| 23 | Add back credits from prior years Ken Fisch invoices | 7,175 | 19 | 23 |
| 24 | Back out Americans for Job Security (PAC Dues) | (834) | 20 | 24 |
| 25 | Adj for ABC related party profit-Pg12 | (2) | 30 | 25 |
| 26 | Adj for ABC related party profit-Pg13 | (11) | 30 | 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 | (84,762) | | 49 |

VII. RELATED PARTIES

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

| 1 OWNERS | | 2 RELATED NURSING HOMES | | 3 OTHER RELATED BUSINESS ENTITIES | | |
|-----------------------|-------------|-------------------------|------|-----------------------------------|------|------------------|
| Name | Ownership % | Name | City | Name | City | Type of Business |
| The Alden Group, 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: | |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|----|
| 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 | | \$ | | | \$ | \$ | 1 |
| 2 | V | | | | | | | 2 |
| 3 | V | | | | | | | 3 |
| 4 | V | | | | | | | 4 |
| 5 | V | | | | | | | 5 |
| 6 | V | | | | | | | 6 |
| 7 | V | | | | | | | 7 |
| 8 | V | | | | | | | 8 |
| 9 | V | | | | | | | 9 |
| 10 | V | | | | | | | 10 |
| 11 | V | | | | | | | 11 |
| 12 | V | | | | | | | 12 |
| 13 | V | | | | | | | 13 |
| 14 | Total | | \$ | | | \$ | \$ * | 14 |

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

VII. RELATED PARTIES (continued)

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

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

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: |
|------------|-------|----------------------------------|------------|---------------------------------|----------------------|--|--|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) |
| 15 | V | 5 Utilities | \$ | Alden Management Services, Inc. | 0.00% | \$ 1,690 | \$ 1,690 |
| 16 | V | 24 Travel/Seminar | | Alden Management Services, Inc. | | 1,965 | 1,965 |
| 17 | V | 25 Other Admin Travel | | Alden Management Services, Inc. | | 6,747 | 6,747 |
| 18 | V | 26 Insurance | | Alden Management Services, Inc. | | 111 | 111 |
| 19 | V | 20 Dues/Subscriptions | 24,600 | Alden Management Services, Inc. | | 306 | (24,294) |
| 20 | V | 30 Depreciation | | Alden Management Services, Inc. | | 2,842 | 2,842 |
| 21 | V | 32 Amortization | | Alden Management Services, Inc. | | 34 | 34 |
| 22 | V | 33 Real Estate Tax | | Alden Management Services, Inc. | | 2,529 | 2,529 |
| 23 | V | 35 Rent-Equip/Vehic | | Alden Management Services, Inc. | | 21,141 | 21,141 |
| 24 | V | 32 Interest | | Alden Management Services, Inc. | | 54,455 | 54,455 |
| 25 | V | 1 Dietary Salary | | Alden Management Services, Inc. | | 3,199 | 3,199 |
| 26 | V | 3 Housekeeping Salary | | Alden Management Services, Inc. | | 2,246 | 2,246 |
| 27 | V | 7 Employee Benef-Gen'l Servs | | Alden Management Services, Inc. | | 3,031 | 3,031 |
| 28 | V | 10 Nurs/Med Rec Salary | | Alden Management Services, Inc. | | 68,498 | 68,498 |
| 29 | V | 15 Employee Benef-Health Care | | Alden Management Services, Inc. | | 4,318 | 4,318 |
| 30 | V | 17 Administrative Salary | | Alden Management Services, Inc. | | 43,345 | 43,345 |
| 31 | V | 27 Employee Benef-Administrative | | Alden Management Services, Inc. | | 26,640 | 26,640 |
| 32 | V | 19 Professional Fees | 338,954 | Alden Management Services, Inc. | | 22,414 | (316,540) |
| 33 | V | 21 Gen'l & Admin | | Alden Management Services, Inc. | | 133,954 | 133,954 |
| 34 | V | 6 Repair & Mainten. | 18,427 | Alden Management Services, Inc. | | 19,045 | 618 |
| 35 | V | | | | | | |
| 36 | V | | | | | | |
| 37 | V | | | | | | |
| 38 | V | | | | | | |
| 39 | Total | | \$ 381,981 | | | \$ 418,510 | \$ * 36,529 |

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 | \$ 10,800 | Prism Health Care Services, Inc. | 0.00% | \$ 2,733 | \$ (8,067) |
| 16 | V | 1 Diet Salary | | Prism Health Care Services, Inc. | | 6,315 | 6,315 |
| 17 | V | 2 Tube Feeding | 42,924 | Prism Health Care Services, Inc. | | 12,558 | (30,366) |
| 18 | V | 10 Equipment Rental | 6,660 | Prism Health Care Services, Inc. | | 9,911 | 3,251 |
| 19 | V | 39 Ancillary Supplies | 76,828 | Prism Health Care Services, Inc. | | 40,956 | (35,872) |
| 20 | V | 21 Salary - G & A | | Prism Health Care Services, Inc. | | 9,998 | 9,998 |
| 21 | V | 27 Employee Benefit | | Prism Health Care Services, Inc. | | 1,768 | 1,768 |
| 22 | V | 7 Employee Benefit | | Prism Health Care Services, Inc. | | 618 | 618 |
| 23 | V | 21 General and Administrative | | Prism Health Care Services, Inc. | | 6,641 | 6,641 |
| 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 | | \$ 137,212 | | | \$ 91,498 | \$ * (45,714) |

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 | \$ 105,262 | Forum Extended Care Services II, Inc. | 0.00% | \$ 153,039 | \$ 47,777 | 15 |
| 16 | V | 39 I.V. | 72,253 | Forum Extended Care Services II, Inc. | | 10,535 | (61,718) | 16 |
| 17 | V | 39 Wound Care | 9,577 | Forum Extended Care Services II, Inc. | | 7,636 | (1,941) | 17 |
| 18 | V | 10 House Stock | 3,211 | Forum Extended Care Services II, Inc. | | 3,026 | (185) | 18 |
| 19 | V | 10 Pharmacy Consult. | 2,304 | Forum Extended Care Services II, Inc. | | 3,286 | 982 | 19 |
| 20 | V | 27 Employ. Vaccin. | 1,012 | Forum Extended Care Services II, Inc. | | 807 | (205) | 20 |
| 21 | V | 27 Employ. Benefits: G & A | | Forum Extended Care Services II, Inc. | | 1,105 | 1,105 | 21 |
| 22 | V | 21 Salary - G&A | | Forum Extended Care Services II, Inc. | | 9,513 | 9,513 | 22 |
| 23 | V | 21 Gen'l & Admin | | Forum Extended Care Services II, Inc. | | 6,223 | 6,223 | 23 |
| 24 | V | 32 Interest | | Forum Extended Care Services II, Inc. | | 1,292 | 1,292 | 24 |
| 25 | V | 33 Real Estate Tax | | Forum Extended Care Services II, Inc. | | 75 | 75 | 25 |
| 26 | V | 30 Depreciation | | Forum Extended Care Services II, Inc. | | 1,348 | 1,348 | 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 | | \$ 193,619 | | | \$ 197,885 | \$ * 4,266 | 39 |

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 | \$ 295,875 | Community Physical Therapy & Associates, Ltd. | 0.00% | \$ 230,962 | \$ (64,913) | 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 | | \$ 295,875 | | | \$ 230,962 | \$ * | (64,913) | 39 |

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

| 1 | | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------------|-------|------|---------------------------|------------------------------|--|--|--|---------------|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) | | |
| 15 | V | 6 | Repairs and Maintenance | \$ 17,678 | Alden Bennett Construction Company, Inc. | 0.00% | \$ 17,577 | \$ (101) | 15 |
| 16 | V | | | | | | | | 16 |
| 17 | V | | | | | | | | 17 |
| 18 | V | | | | | | | | 18 |
| 19 | V | | | | | | | | 19 |
| 20 | V | | | | | | | | 20 |
| 21 | V | | | | | | | | 21 |
| 22 | V | | | | | | | | 22 |
| 23 | V | | | | | | | | 23 |
| 24 | V | | | | | | | | 24 |
| 25 | V | | | | | | | | 25 |
| 26 | V | | | | | | | | 26 |
| 27 | V | | | | | | | | 27 |
| 28 | V | | | | | | | | 28 |
| 29 | V | | | | | | | | 29 |
| 30 | V | | | | | | | | 30 |
| 31 | V | | | | | | | | 31 |
| 32 | V | | | | | | | | 32 |
| 33 | V | | | | | | | | 33 |
| 34 | V | | | | | | | | 34 |
| 35 | V | | | | | | | | 35 |
| 36 | V | | | | | | | | 36 |
| 37 | V | | | | | | | | 37 |
| 38 | V | | | | | | | | 38 |
| 39 | Total | | \$ 17,678 | | | \$ 17,577 | \$ * | (101) | 39 |

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

STATE OF ILLINIOS

Facility Name & ID Number Aiden Lincoln Rehab & Health Care Center Provider No. 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 | 175,877 | 0.916 | 0.02 | Salary | \$ 4,123 | 17-7 | 1 |
| 2 | Lauren Magnusson | Dir. Of Clinical Servi | Technical Nursing | 0.00 | 65,666 | 0.916 | 0.02 | Salary | 1,539 | 10-7 | 2 |
| 3 | Terry Magnusson | Dir. of Purchasing | Supervise Mainten | 0.00 | 38,203 | 0.916 | 0.02 | Salary | 896 | 6-7 | 3 |
| 4 | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc. | | | | | | | | | | 6 |
| 7 | B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff. | | | | | | | | | | 7 |
| 8 | C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers. | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | TOTAL | \$ 6,558 | | 13 |

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 * | 30 | \$ 73,771 | \$ | 27,865 | \$ 1,690 | 1 | |
| 2 | 24 | Travel/Seminar | patient days * | 30 | 85,812 | | 27,865 | 1,965 | 2 | |
| 3 | 25 | Other Admin Travel | patient days * | 30 | 294,582 | | 27,865 | 6,747 | 3 | |
| 4 | 26 | Insurance | patient days * | 30 | 4,828 | | 27,865 | 111 | 4 | |
| 5 | 20 | Dues/Subscriptions | patient days * | 30 | 13,344 | | 27,865 | 306 | 5 | |
| 6 | 30 | Depreciation | no. of providers | 30 | 98,652 | | 1 | 2,842 | 6 | |
| 7 | 32 | Amortization | patient days * | 30 | 1,500 | | 27,865 | 34 | 7 | |
| 8 | 33 | Real Estate Tax | patient days * | 30 | 125,958 | | 27,865 | 2,529 | 8 | |
| 9 | 35 | Rent-Equip/Vehic | patient days * | 30 | 923,032 | | 27,865 | 21,141 | 9 | |
| 10 | 32 | Interest | patient days * | 30 | 1,783,086 | | 27,865 | 54,455 | 10 | |
| 11 | 1 | Dietary Salary | patient days * | 30 | 139,689 | 139,689 | 27,865 | 3,199 | 11 | |
| 12 | 3 | Housekeeping Salary | patient days * | 30 | 98,076 | 98,076 | 27,865 | 2,246 | 12 | |
| 13 | 7 | Employee Benef-Gen'l Servs | patient days * | 30 | 131,320 | | 27,865 | 3,031 | 13 | |
| 14 | 10 | Nurs/Med Rec Salary | patient days * | 30 | 1,256,694 | 1,256,694 | 27,865 | 68,498 | 14 | |
| 15 | 15 | Employee Benef-Health Care | patient days * | 30 | 187,098 | | 27,865 | 4,318 | 15 | |
| 16 | 17 | Administrative Salary | patient days * | 30 | 2,118,865 | 2,118,865 | 27,865 | 43,345 | 16 | |
| 17 | 27 | Employee Benef-Administrative | patient days * | 30 | 1,165,559 | | 27,865 | 26,640 | 17 | |
| 18 | 19 | Professional Fees | patient days * | 30 | 978,599 | 605,253 | 27,865 | 22,414 | 18 | |
| 19 | 21 | Gen'l & Admin | patient days * | 30 | 5,924,144 | 5,104,656 | 27,865 | 133,954 | 19 | |
| 20 | 6 | Repair & Mainten. | patient days * | 30 | 831,505 | 644,276 | 27,865 | 19,045 | 20 | |
| 21 | | | | | | | | | 21 | |
| 22 | | | | | | | | | 22 | |
| 23 | | * The allocation is based on patient days, however, there may be some instances in which a home office cost could be directly associated with the provider | | | | | | | | 23 |
| 24 | | In those rare cases, the cost would not be part of the overall allocation process but directly allocated to the appropriate provider | | | | | | | | 24 |
| 25 | TOTALS | | | | \$ 16,236,114 | \$ 9,967,509 | | \$ 418,510 | 25 | |

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 |
|-------------------------------------|----------------------------|-----------------|--------------------------|--------------|----------------|---------------|--------------------------|-----------------------------------|---|----|--------|
| | | | | | | Original | Balance | | | | |
| 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 | | | | | | | | | |
| A. Directly Facility Related | | | | | | | | | | | |
| Long-Term | | | | | | | | | | | |
| 1 | | | | | | \$ | \$ | | | \$ | 1 |
| 2 | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 34 |
| 5 | | | | | | | | | | | 1,867 |
| Working Capital | | | | | | | | | | | |
| 6 | | | | | | | | | | | 6 |
| 7 | | x | | | | | | | | | 54,455 |
| 8 | | x | | | | | | | | | 1,292 |
| 9 | TOTAL Facility Related | | | | | \$ | \$ | | | \$ | 57,648 |
| B. Non-Facility Related* | | | | | | | | | | | |
| 10 | | | | | | | | | | | (898) |
| 11 | | | | | | | | | | | |
| 12 | | | | | | | | | | | |
| 13 | | | | | | | | | | | |
| 14 | TOTAL Non-Facility Related | | | | | \$ | \$ | | | \$ | (898) |
| 15 | TOTALS (line 9+line14) | | | | | \$ | \$ | | | \$ | 56,750 |

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Lincoln Rehab & Health Care Cente COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040709

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

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

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of t cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

| (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 supplement</u> | <u>Related Party-Alden Management Ser</u> | <u>\$ 295,853.00</u> | <u>\$ 2,529.00</u> |
| 2. <u>See attached supplement</u> | <u>Related Party-Forum Professional Ce</u> | <u>\$ 28,917.00</u> | <u>\$ 75.00</u> |
| 3. <u>14-28-108-023-0000</u> | <u>Nursing Home Facility</u> | <u>\$ 107,388.88</u> | <u>\$ 107,388.88</u> |
| 4. _____ | _____ | \$ _____ | \$ _____ |
| 5. _____ | _____ | \$ _____ | \$ _____ |
| 6. _____ | _____ | \$ _____ | \$ _____ |
| 7. _____ | _____ | \$ _____ | \$ _____ |
| 8. _____ | _____ | \$ _____ | \$ _____ |
| 9. _____ | _____ | \$ _____ | \$ _____ |
| 10. _____ | _____ | \$ _____ | \$ _____ |
| TOTALS | | \$ <u>432,158.88</u> | \$ <u>109,992.88</u> |

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

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

0040709 Report Period Beginning:

1/1/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 B. General Construction Type: Exterior brick Frame steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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 | | | | \$ | 1 |
| 2 | | | | | 2 |
| 3 | TOTALS | | | \$ | 3 |

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

0040709

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|-------|--|---------------|------------------|--------|---------------------------|---------------|----------------------------|-------------|--------------------------|
| Beds* | FOR BHF USE ONLY | Year Acquired | Year Constructed | Cost | Current Book Depreciation | Life in Years | Straight Line Depreciation | Adjustments | Accumulated Depreciation |
| 4 | | | | \$ | \$ | | \$ | \$ | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | Related Party-Forum | | 1978 | 14,056 | | 25 | | | 14,056 |
| | Improvement Type** | | | | | | | | |
| 9 | Sprinkler heads | | 1995 | 1,832 | 73 | 25 | 73 | | 970 |
| 10 | Roof repairs | | 1995 | 2,000 | | 10 | | | 2,000 |
| 11 | Installed Electric AMPS | | 1996 | 1,870 | | 5 | | | 1,870 |
| 12 | Signs | | 1996 | 1,800 | | 10 | | | 1,800 |
| 13 | Water Heater | | 1997 | 6,180 | | 5 | | | 6,180 |
| 14 | Replace Pipes | | 1997 | 5,949 | | 5 | | | 5,949 |
| 15 | Exhaust Fans | | 1997 | 8,403 | | 5 | | | 8,403 |
| 16 | Washing machine motor | | 1998 | 1,576 | | 8 | | | 1,576 |
| 17 | ABC (General construction) Major repairs/improvement | | 1999 | 5,713 | 571 | 10 | 571 | | 5,426 |
| 18 | ABC (General construction) Major repairs/improvement | | 1999 | 2,326 | 233 | 10 | 233 | | 2,192 |
| 19 | ABC (General construction) Major repairs/improvement | | 1999 | 2,092 | 209 | 10 | 209 | | 1,969 |
| 20 | ABC (General construction) Major repairs/improvement | | 1999 | 1,870 | 187 | 10 | 187 | | 1,714 |
| 21 | ABC (General construction) Major repairs/improvement | | 1999 | 12,658 | 1,266 | 10 | 1,266 | | 11,604 |
| 22 | ABC (General construction) Major repairs/improvement | | 1999 | 2,250 | 225 | 10 | 225 | | 2,044 |
| 23 | ABC (General construction) Major repairs/improvement | | 1999 | 10,225 | 1,022 | 10 | 1,022 | | 9,286 |
| 24 | Climate Services (exhaust fan) | | 1999 | 2,280 | | 5 | | | 2,280 |
| 25 | Oxygen exhaust system | | 2000 | 8,555 | 1,069 | 8 | 1,069 | | 8,555 |
| 26 | Elevator door repair | | 2000 | 1,518 | | 5 | | | 1,518 |
| 27 | Lawn Sprinkler | | 2000 | 15,500 | 620 | 25 | 620 | | 5,167 |
| 28 | ABC (General construction) Major repairs/improvement | | 2000 | 6,937 | | 5 | | | 6,937 |
| 29 | ABC (General construction) New hot water system | | 2000 | 49,596 | 2,480 | 20 | 2,480 | | 21,906 |
| 30 | ABC (General construction) Replace showers | | 2000 | 23,903 | 2,390 | 10 | 2,390 | | 19,918 |
| 31 | Replace Fire Pump | | 2001 | 3,230 | 162 | 20 | 162 | | 1,294 |
| 32 | 14 Kilowatt water heater booster | | 2001 | 2,783 | 278 | 10 | 278 | | 2,040 |
| 33 | ABC (General construction) Major repairs/improvement | | 2001 | 3,402 | | 5 | | | 3,402 |
| 34 | | | | | | | | | |
| 35 | | | | | | | | | |
| 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

STATE OF ILLINOIS

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

0040709

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|--------------------|---|------|---------------------------|---------------|----------------------------|-------------|--------------------------|---|----|
| Improvement Type** | Year Constructed | Cost | Current Book Depreciation | Life in Years | Straight Line Depreciation | Adjustments | Accumulated Depreciation | | |
| 37 | Capps Plumbing (pipe & wall repair) | 2002 | \$ 1,985 | \$ | 5 | \$ | \$ 1,985 | | 37 |
| 38 | ABC (misc construction work) | 2002 | 3,442 | | 5 | | 3,442 | | 38 |
| 39 | ABC (repair ejector pump) | 2002 | 7,893 | | 5 | | 7,893 | | 39 |
| 40 | Capps Plumbing (water pump) | 2002 | 3,275 | 164 | 20 | 164 | 1,052 | | 40 |
| 41 | TNS (DSL Cable) | 2004 | 1,358 | 271 | 5 | 271 | 1,333 | | 41 |
| 42 | ABC (1st Floors Stairs) | 2004 | 1,699 | 170 | 10 | 170 | 694 | | 42 |
| 43 | Oak Fire security System, new base dual zone card | 2005 | 1,350 | 270 | 5 | 270 | 833 | | 43 |
| 44 | Washtown (repair Washer motor) | 2005 | 1,563 | 313 | 5 | 313 | 1,069 | | 44 |
| 45 | ABC (repair Mop basin) | 2005 | 1,613 | 323 | 5 | 323 | 1,103 | | 45 |
| 46 | | | | | | | | | 46 |
| 47 | ABC - seal holes and replace fill materials 3rd floor | 2006 | 5,793 | 579 | 10 | 579 | 1,592 | | 47 |
| 48 | TopNotch - booster heater | 2006 | 3,217 | 322 | 10 | 322 | 724 | | 48 |
| 49 | | | | | | | | | 49 |
| 50 | ABC - wall covering | 2007 | 10,494 | 1,049 | 10 | 1,049 | 1,749 | | 50 |
| 51 | | | | | | | | | 51 |
| 52 | ABC - HM door and frame | 2008 | 3,270 | 218 | 10 | 218 | 218 | | 52 |
| 53 | Central States - springkler system | 2008 | 3,700 | | 5 | | | | 53 |
| 54 | ABC - patio door | 2008 | 2,501 | 63 | 10 | 63 | 63 | | 54 |
| 55 | ABC - repair electrical room and patio doors | 2008 | 2,915 | 24 | 10 | 24 | 24 | | 55 |
| 56 | | | | | | | | | 56 |
| 57 | | | | | | | | | 57 |
| 58 | | | | | | | | | 58 |
| 59 | | | | | | | | | 59 |
| 60 | | | | | | | | | 60 |
| 61 | | | | | | | | | 61 |
| 62 | | | | | | | | | 62 |
| 63 | | | | | | | | | 63 |
| 64 | | | | | | | | | 64 |
| 65 | | | | | | | | | 65 |
| 66 | | | | | | | | | 66 |
| 67 | | | | | | | | | 67 |
| 68 | | | | | | | | | 68 |
| 69 | | | | | | | | | 69 |
| 70 | TOTAL (lines 4 thru 69) | | \$ 254,572 | \$ 14,552 | | \$ 14,552 | \$ 173,830 | | 70 |

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

STATE OF ILLINOIS

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

0040709

Report Period Beginning:

1/1/08

Ending:

12/31/08

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 | | \$ 254,572 | \$ 14,552 | | \$ 14,552 | \$ | \$ 173,830 | 1 |
| 2 | | | | | | | | | 2 |
| 3 | Related Party-Forum Prof Center Building: | | | | | | | | 3 |
| 4 | Leasehold Improvement-Remodeling | 1980 | 10,666 | | 15 | | | 10,666 | 4 |
| 5 | Leasehold Improvement-Remodeling | 1980 | 16,708 | | 20 | | | 16,708 | 5 |
| 6 | Leasehold Improvement-Tenant Improvem | 1987 | 864 | | 13 | | | 864 | 6 |
| 7 | Leasehold Improvement-AMS Remode | 1988 | 13,861 | | 10 | | | 13,861 | 7 |
| 8 | Leasehold Improvement-Roof | 1994 | 3,097 | 194 | 16 | 194 | | 2,711 | 8 |
| 9 | Leasehold Improvement-Build.Improv | 1996 | 1,092 | 68 | 16 | 68 | | 884 | 9 |
| 10 | Leasehold Improvement-Asphalting | 2000 | 85 | | 3 | | | 85 | 10 |
| 11 | Leasehold Improvement-DAI | 2001 | 149 | 15 | 10 | 15 | | 107 | 11 |
| 12 | Leasehold Improvement-Bathrooms | 2002 | 645 | 58 | 7 | 58 | | 436 | 12 |
| 13 | Leasehold Improvement-Suite Renovator | 2003 | 1,583 | 157 | 10 | 157 | | 950 | 13 |
| 14 | Leasehold Improvement-Plumbing, Construct, Concrete, Doors, et | 2004 | 1,982 | 375 | 7 | 375 | | 1,546 | 14 |
| 15 | Leasehold Improvement-sidewalks-City of Chic | 2007 | 102 | 20 | 5 | 20 | | 41 | 15 |
| 16 | Leasehold Improvement-Carpet: Superior Install | 2007 | 94 | 19 | 5 | 19 | | 37 | 16 |
| 17 | Leasehold Improvement-Condensing Unit: Suite 140 | 2007 | 813 | 116 | 5 | 116 | | 232 | 17 |
| 18 | Leasehold Improvement-Add-on Improvement, fixture bas | 1980 | 69 | | 23 | | | 69 | 18 |
| 19 | Leasehold Improvement-Add-on Improvement, lighting bas | 2001 | 119 | | 5 | | | 119 | 19 |
| 20 | Leasehold Improvements-fire extinguisher | 2007 | 22 | 4 | 5 | 4 | | 6 | 20 |
| 21 | Leasehold Improvements-paving/glasswork/hvac/carpe | 2008 | 392 | 24 | 5 | 24 | | 24 | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | | | | | | | | 23 |
| 24 | Related Party-AMS: | | | | | | | | 24 |
| 25 | Leasehold Improvement-Remodeling | 1993 | 5,740 | | 7 | | | 5,740 | 25 |
| 26 | Leasehold Improvement-Remodeling | 2002 | 4,699 | 671 | 7 | 671 | | 3,944 | 26 |
| 27 | Leasehold Improvement-Remodeling | 2003 | 4,915 | 702 | 7 | 702 | | 4,110 | 27 |
| 28 | | | | | | | | | 28 |
| 29 | | | | | | | | | 29 |
| 30 | Forum Extended Care, LLC-building/building impro | 1999 | 9,295 | 232 | 30 | 232 | | 2,372 | 30 |
| 31 | Adj for ABC related party profit | 2008 | (50) | (2) | | (2) | | (2) | 31 |
| 32 | | | | | | | | | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 331,515 | \$ 17,206 | | \$ 17,206 | \$ | \$ 239,340 | 34 |

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08

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 | \$ 181,144 | \$ 18,530 | \$ 18,530 | \$ | various | \$ 110,994 | 71 |
| 72 | Current Year Purchases | 30,589 | 2,438 | 2,438 | | various | 2,438 | 72 |
| 73 | Fully Depreciated Assets | 141,404 | 2,415 | 2,415 | | various | 141,404 | 73 |
| 74 | | | | | | | | 74 |
| 75 | TOTALS | \$ 353,137 | \$ 23,383 | \$ 23,383 | \$ | | \$ 254,836 | 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 | various | 98-'04 | 4,563 | | | | | 4,563 | 79 |
| 80 | TOTALS | | | \$ 4,563 | \$ | \$ | \$ | | \$ 4,563 | 80 |

E. Summary of Care-Related Assets

| | 1 | 2 | |
|----|---|------------|-------|
| | Reference | 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) | \$ 689,215 | 81 |
| 82 | Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable) | \$ 40,589 | 82 |
| 83 | Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable) | \$ 40,589 | 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) | \$ 498,739 | 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: T.L. Enterprises

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
If NO, see instructions.

| | 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: | 96 | | \$ 529,425 | 16 | | 3 |
| 4 | Additions | | | | | | 4 |
| 5 | | | | | | | 5 |
| 6 | | | | | | | 6 |
| 7 | TOTAL | 96 | | \$ 529,425 | | | 7 |

10. Effective dates of current rental agreement:
Beginning 03/01/95
Ending 01/01/10

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

| | Fiscal Year Ending | Annual Rent |
|-----|--------------------|------------------|
| 12. | <u>12/31/2009</u> | \$ <u>varies</u> |
| 13. | <u>12/31/2010</u> | \$ <u>varies</u> |
| 14. | <u>12/31/2011</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: Purchase Option Deposit *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 11,656 Description: copy machine lease and other office equipment lease (GL6861 and 6859)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

| | 1 Use | 2 Model Year and Make | 3 Monthly Lease Payment | 4 Rental Expense for this Period | |
|----|---------------------------------|-----------------------------|-------------------------------|--|----|
| 17 | <u>Related Party - AMS (6A)</u> | | \$ ##### | \$ 12,145 | 17 |
| 18 | | | | | 18 |
| 19 | | | | | 19 |
| 20 | | | | | 20 |
| 21 | TOTAL | | \$ ##### | \$ 12,145 | 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.

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 nurses 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 | | | |
|------------------------------------|-----------|-----------|----------|-------|
| | 1 | 2 | 3 | 4 |
| | 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) | \$ | | | |

- (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.

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 | |

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

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

| | Service | 1 Schedule V Line & Column Reference | 2 | | 3 | | 4 | | 5 | 6 Supplies (Actual or Allocated) | 7 Total Units (Column 2 + 4) | 8 Total Cost (Col. 3 + 5 + 6) | |
|----|--|---|---------------------|------|---|------|---|------------|------------|---|------------------------------------|-------------------------------------|--|
| | | | Staff | | Outside Practitioner (other than consultant) | | | | | | | | |
| | | | Units of Service | Cost | Units | Cost | | | | | | | |
| 1 | Licensed Occupational Therapist | 39-3 | hrs | \$ | | | | \$ 137,549 | \$ | | \$ 137,549 | 1 | |
| 2 | Licensed Speech and Language Development Therapist | 39-3 | hrs | | | | | 6,200 | | | 6,200 | 2 | |
| 3 | Licensed Recreational Therapist | | hrs | | | | | | | | | 3 | |
| 4 | Licensed Physical Therapist | 39-3 | hrs | | | | | 152,125 | | | 152,125 | 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 | | | | | | 153,039 | | 153,039 | 9 | |
| 10 | Psychological Services (Evaluation and Diagnosis/ Behavior Modification) | | hrs | | | | | | | | | 10 | |
| 11 | Academic Education | | hrs | | | | | | | | | 11 | |
| 12 | Other (specify): | 39-1, 39-3, if any | | | | | | | | | | 12 | |
| 13 | Other (specify): | See Pg 16A | | | | | | (64,913) | 120,351 | | 55,438 | 13 | |
| 14 | TOTAL | | | \$ | | | | \$ 230,961 | \$ 273,390 | | \$ 504,351 | 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.

UPDATED
TV 03/17/09

Page 16

Col 5: PT,OT, & ST

Col 6: Supplies

XIV. Special Services (Direct Cost)

| Service Description | Col. 1: Ref. No. | To Pg 16: Col. No. | |
|--|------------------|--------------------|--------------|
| 1. OT | 39-3 | To Col 5 | \$137,548.60 |
| 2. ST | 39-3 | To Col 5 | 6,200.41 |
| 3. | | | |
| 4. PT | 39-3 | To Col 5 | 152,125.66 |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| Pharmacy Supplies per GL | | | 105,261.91 |
| Manual Input from Related Party- Forum Drugs | | | 47,777.00 |
| | | | ----- |
| 9. Total to line 9 Pharmacy | See Pg 16A | To Col 6 | 153,038.91 |
| | | | ----- |
| 10. | | | |
| 11. | | | |
| 12. Exceptional Care-Salaries: | See pg 16A | To Col. 3 | 0.00 |
| 12. Exceptional Care-Supplies: | See pg 16A | To Col. 6 | 0.00 |
| Total Exceptional Care (Line 12, Col 8) | | | 0.00 |
| | | | ----- |
| 13. Other: | See Pg 16A | | |
| 13. Col 5: Manual Input: Related Party - CPT | | To Col 5 | (64,913.00) |
| Other | | | 177,753.65 |
| Manual Input: Related Party - Prism | | | (35,871.00) |
| Manual Input: Related Party FECII - I.V. | | | (61,718.00) |
| Manual Input: Related Party FECII - Wound Care | | | (1,941.00) |
| Oxygen, from reclass worksheet | | | 42,127.00 |
| | | | ----- |
| 13. Col 6: Supplies Total | | To Col 6 | 120,350.65 |
| | | | ----- |
| 13. Total Line 13, Column 8 | | | 55,437.65 |
| | | | ----- |
| 14. Total | | | 504,351.23 |
| | | | ===== |

STATE OF ILLINOIS

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 1/1/08 Ending: 12/31/08
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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 36,044) | 1,229,406 | | 3 |
| 4 | Supply Inventory (priced at) | | | 4 |
| 5 | Short-Term Investments | | | 5 |
| 6 | Prepaid Insurance | 3,914 | | 6 |
| 7 | Other Prepaid Expenses | 1,841 | | 7 |
| 8 | Accounts Receivable (owners or related parties) | | | 8 |
| 9 | Other(specify): | | | 9 |
| 10 | TOTAL Current Assets (sum of lines 1 thru 9) | \$ 1,235,161 | \$ | 10 |
| B. Long-Term Assets | | | | |
| 11 | Long-Term Notes Receivable | | | 11 |
| 12 | Long-Term Investments | | | 12 |
| 13 | Land | | | 13 |
| 14 | Buildings, at Historical Cost | | | 14 |
| 15 | Leasehold Improvements, at Historical Cost | 340,081 | | 15 |
| 16 | Equipment, at Historical Cost | 305,277 | | 16 |
| 17 | Accumulated Depreciation (book methods) | (434,095) | | 17 |
| 18 | Deferred Charges | | | 18 |
| 19 | Organization & Pre-Operating Costs | | | 19 |
| 20 | Accumulated Amortization - Organization & Pre-Operating Costs | | | 20 |
| 21 | Restricted Funds | 180,654 | | 21 |
| 22 | Other Long-Term Assets (specify <u>Purchase Option</u>) | 288,000 | | 22 |
| 23 | Other(specify): | | | 23 |
| 24 | TOTAL Long-Term Assets (sum of lines 11 thru 23) | \$ 679,917 | \$ | 24 |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | \$ 1,915,078 | \$ | 25 |

| | | 1 | 2 | |
|--|--|--------------|----------------------|----|
| | | Operating | After Consolidation* | |
| C. Current Liabilities | | | | |
| 26 | Accounts Payable | \$ 695,222 | \$ | 26 |
| 27 | Officer's Accounts Payable | | | 27 |
| 28 | Accounts Payable-Patient Deposits | 121,222 | | 28 |
| 29 | Short-Term Notes Payable | | | 29 |
| 30 | Accrued Salaries Payable | 169,420 | | 30 |
| 31 | Accrued Taxes Payable (excluding real estate taxes) | 30,029 | | 31 |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | 110,600 | | 32 |
| 33 | Accrued Interest Payable | | | 33 |
| 34 | Deferred Compensation | | | 34 |
| 35 | Federal and State Income Taxes | | | 35 |
| Other Current Liabilities(specify): | | | | |
| 36 | <u>Accrued exp/Deferred Rent</u> | 258,752 | | 36 |
| 37 | <u>Due to 3rd Parties</u> | 23,102 | | 37 |
| 38 | TOTAL Current Liabilities (sum of lines 26 thru 37) | \$ 1,408,347 | \$ | 38 |
| D. Long-Term Liabilities | | | | |
| 39 | Long-Term Notes Payable | | | 39 |
| 40 | Mortgage Payable | | | 40 |
| 41 | Bonds Payable | | | 41 |
| 42 | Deferred Compensation | | | 42 |
| Other Long-Term Liabilities(specify): | | | | |
| 43 | <u>Due to Affiliates</u> | 516,198 | | 43 |
| 44 | | | | 44 |
| 45 | TOTAL Long-Term Liabilities (sum of lines 39 thru 44) | \$ 516,198 | \$ | 45 |
| 46 | TOTAL LIABILITIES (sum of lines 38 and 45) | \$ 1,924,545 | \$ | 46 |
| 47 | TOTAL EQUITY(page 18, line 24) | \$ (9,467) | \$ | 47 |
| 48 | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | \$ 1,915,078 | \$ | 48 |

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

| | | 1 Total | |
|-----------------------------------|--|--------------|------|
| 1 | Balance at Beginning of Year, as Previously Reported | \$ 323,932 | 1 |
| 2 | Restatements (describe): | | 2 |
| 3 | | | 3 |
| 4 | | | 4 |
| 5 | | | 5 |
| 6 | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ 323,932 | 6 |
| A. Additions (deductions): | | | |
| 7 | NET Income (Loss) (from page 19, line 43) | (333,399) | 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) | \$ (333,399) | 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) | \$ (9,467) | 24 * |

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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

0040709

Report Period Beginning: 1/1/08

Ending:

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12/31/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

| | | 1 | |
|--|---|--------------|-----|
| Revenue | | Amount | |
| A. Inpatient Care | | | |
| 1 | Gross Revenue -- All Levels of Care | \$ 4,784,888 | 1 |
| 2 | Discounts and Allowances for all Levels | () | 2 |
| 3 | SUBTOTAL Inpatient Care (line 1 minus line 2) | \$ 4,784,888 | 3 |
| B. Ancillary Revenue | | | |
| 4 | Day Care | | 4 |
| 5 | Other Care for Outpatients | | 5 |
| 6 | Therapy | 53,715 | 6 |
| 7 | Oxygen | 26,589 | 7 |
| 8 | SUBTOTAL Ancillary Revenue (lines 4 thru 7) | \$ 80,304 | 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 | 191 | 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 | 19,188 | 21 |
| 22 | Laundry | | 22 |
| 23 | SUBTOTAL Other Operating Revenue (lines 9 thru 22) | \$ 19,379 | 23 |
| D. Non-Operating Revenue | | | |
| 24 | Contributions | | 24 |
| 25 | Interest and Other Investment Income*** | 898 | 25 |
| 26 | SUBTOTAL Non-Operating Revenue (lines 24 and 25) | \$ 898 | 26 |
| E. Other Revenue (specify):**** | | | |
| 27 | Settlement Income (Insurance, Legal, Etc.) | | 27 |
| 28 | Misc income/interest legal fees/jury duty/others | 10,268 | 28 |
| 28a | (see attached) | | 28a |
| 29 | SUBTOTAL Other Revenue (lines 27, 28 and 28a) | \$ 10,268 | 29 |
| 30 | TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) | \$ 4,895,737 | 30 |

| | | 2 | |
|-------------------------------------|--|--------------|----|
| Expenses | | Amount | |
| A. Operating Expenses | | | |
| 31 | General Services | 933,867 | 31 |
| 32 | Health Care | 1,683,392 | 32 |
| 33 | General Administration | 1,230,052 | 33 |
| B. Capital Expense | | | |
| 34 | Ownership | 750,230 | 34 |
| C. Ancillary Expense | | | |
| 35 | Special Cost Centers | 578,891 | 35 |
| 36 | Provider Participation Fee | 52,704 | 36 |
| D. Other Expenses (specify): | | | |
| 37 | | | 37 |
| 38 | | | 38 |
| 39 | | | 39 |
| 40 | TOTAL EXPENSES (sum of lines 31 thru 39)* | \$ 5,229,136 | 40 |
| 41 | Income before Income Taxes (line 30 minus line 40)** | (333,399) | 41 |
| 42 | Income Taxes | | 42 |
| 43 | NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) | \$ (333,399) | 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.

STATE OF ILLINOIS

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

0040709

Report Period Beginning:

1/1/08

Ending:

12/31/08

Details of Page 19, Line 28

| | |
|---|--------------------------------|
| Interest on Legal fees | 8,762.00 |
| misc receipts (employee cost - reissue lost checks) | 325.00 |
| Medical records | 95.00 |
| Jury Duty | 34.00 |
| Vending Machine | 326.00 |
| Food rebate | 143.00 |
| Rent - Polling site | 275.00 |
| Adjustment to Prior Invoices | <u>308.00</u> |
| Total | <u><u>10,268.00</u></u> |

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

0040709

Report Period Beginning: 1/1/08

Ending: 12/31/08

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 | 840 | 840 | \$ 27,692 | \$ 32.97 | 1 |
| 2 | Assistant Director of Nursing | | | | | 2 |
| 3 | Registered Nurses | 7,562 | 8,134 | 249,700 | 30.70 | 3 |
| 4 | Licensed Practical Nurses | 18,313 | 19,028 | 501,327 | 26.35 | 4 |
| 5 | CNAs & Orderlies | 41,267 | 44,992 | 523,649 | 11.64 | 5 |
| 6 | CNA Trainees | | | | | 6 |
| 7 | Licensed Therapist | | | | | 7 |
| 8 | Rehab/Therapy Aides | | | | | 8 |
| 9 | Activity Director | 2,148 | 2,148 | 36,901 | 17.18 | 9 |
| 10 | Activity Assistants | 1,639 | 1,767 | 15,681 | 8.87 | 10 |
| 11 | Social Service Workers | 2,080 | 2,080 | 38,638 | 18.58 | 11 |
| 12 | Dietician | | | | | 12 |
| 13 | Food Service Supervisor | 2,080 | 2,080 | 43,798 | 21.06 | 13 |
| 14 | Head Cook | | | | | 14 |
| 15 | Cook Helpers/Assistants | 13,296 | 14,654 | 169,833 | 11.59 | 15 |
| 16 | Dishwashers | | | | | 16 |
| 17 | Maintenance Workers | 2,072 | 2,080 | 60,940 | 29.30 | 17 |
| 18 | Housekeepers | 8,820 | 9,596 | 98,699 | 10.29 | 18 |
| 19 | Laundry | 5,363 | 5,940 | 58,879 | 9.91 | 19 |
| 20 | Administrator | 2,080 | 2,080 | 85,467 | 41.09 | 20 |
| 21 | Assistant Administrator | | | | | 21 |
| 22 | Other Administrative | 3,099 | 3,099 | 82,968 | 26.77 | 22 |
| 23 | Office Manager | | | | | 23 |
| 24 | Clerical | 2,254 | 2,302 | 20,711 | 9.00 | 24 |
| 25 | Vocational Instruction | | | | | 25 |
| 26 | Academic Instruction | | | | | 26 |
| 27 | Medical Director | | | | | 27 |
| 28 | Qualified MR Prof. (QMRP) | | | | | 28 |
| 29 | Resident Services Coordinator | 1,723 | 1,723 | 52,992 | 30.76 | 29 |
| 30 | Habilitation Aides (DD Homes) | | | | | 30 |
| 31 | Medical Records | | | | | 31 |
| 32 | Other Health Care(specify) | | | | | 32 |
| 33 | Other(specify) Alzheimer Supervi | 2,080 | 2,080 | 28,476 | 13.69 | 33 |
| 34 | TOTAL (lines 1 - 33) | 116,716 | 124,623 | \$ 2,096,351 * | \$ 16.82 | 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 | 900/month | \$ 10,800 | 1-3 | 35 |
| 36 | Medical Director | 2775/month | 33,300 | 10-3 | 36 |
| 37 | Medical Records Consultant | | | | 37 |
| 38 | Nurse Consultant | | | | 38 |
| 39 | Pharmacist Consultant | 192/month | 2,304 | 10-3 | 39 |
| 40 | Physical Therapy Consultant | | | | 40 |
| 41 | Occupational Therapy Consultant | | | | 41 |
| 42 | Respiratory Therapy Consultant | | | | 42 |
| 43 | Speech Therapy Consultant | | | | 43 |
| 44 | Activity Consultant | 89/month | 1,072 | 11-3 | 44 |
| 45 | Social Service Consultant | 88/month | 1,056 | 11-3 | 45 |
| 46 | Other(specify) | | | | 46 |
| 47 | | | | | 47 |
| 48 | | | | | 48 |
| 49 | TOTAL (lines 35 - 48) | | \$ 48,532 | | 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 |

XIX. SUPPORT SCHEDULES

| A. Administrative Salaries | | | | D. Employee Benefits and Payroll Taxes | | | F. Dues, Fees, Subscriptions and Promotions | |
|--|-----------------------------|-------------|------------|--|------------|--|---|----------|
| Name | Function | Ownership % | Amount | Description | Amount | Description | Amount | |
| Carrie Groulx | Administrator | 0 | \$ 85,467 | Workers' Compensation Insurance | \$ 47,606 | IDPH License Fee | \$ | |
| | | | | Unemployment Compensation Insurance | 12,904 | Advertising: Employee Recruitment | 100 | |
| | | | | FICA Taxes | 158,601 | Health Care Worker Background Check (Indicate # of checks performed <u>55</u>) | 550 | |
| | | | | Employee Health Insurance | 28,173 | Patient Background Checks <u>86</u> | 860 | |
| | | | | Employee Meals | 21,304 | Surety Bond Fees | 780 | |
| | | | | Illinois Municipal Retirement Fund (IMRF)* | | | | |
| | | | | Union, Health & Welfare | 43,296 | Central Lakeview Merchants | 150 | |
| | | | | Dental & Life | 657 | IL Health Care Associations | 3,704 | |
| | | | | Pension | 13,358 | Related Party - AMS (6A) | 306 | |
| | | | | Relations, Misc Payroll Costs, Drug Tests, 401K match, Vaccinations | 5,286 | Less: Public Relations Expense () | | |
| | | | | Chicago Head Tax | 2,960 | Non-allowable advertising () | | |
| | | | | | | Yellow page advertising () | | |
| TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) | | | \$ 85,467 | TOTAL (agree to Schedule V, line 22, col.8) | \$ 334,145 | TOTAL (agree to Sch. V, line 20, col. 8) | \$ 6,450 | |
| B. Administrative - Other | | | | E. Schedule of Non-Cash Compensation Paid to Owners or Employees | | | G. Schedule of Travel and Seminar** | |
| Description | | | Amount | Description | Line # | Amount | Description | Amount |
| | | | \$ | | | \$ | Out-of-State Travel | \$ |
| | | | | | | | | |
| | | | | | | | In-State Travel | |
| | | | | | | | Related Party - AMS (6A) | 1,965 |
| | | | | | | | | |
| TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement) | | | \$ | | | | Seminar Expense | |
| C. Professional Services | | | | | | | Deming Training | 2,173 |
| Vendor/Payee | Type | | Amount | | | | IL Health Care Assoc - Administrators semin | 2,653 |
| AMS | Management Fees | | \$ 338,954 | | | | Pathway/Prof Training/AMS - Nursing, Sanit | 2,456 |
| Ken Fisch | Legal Fees | | 6,643 | | | | Entertainment Expense () | |
| BDO Seidman | Accounting Fees | | 2,250 | | | | (agree to Sch. V, line 24, col. 8) | |
| Pathway (reclassified to Nursing) | Clinical Support | | 13,460 | | | | TOTAL | \$ 9,247 |
| Ungaretti & Harris | Legal Fees | | 1,729 | | | | | |
| IL Associations of Health Care | Union Matters | | 1,152 | | | | | |
| | | | | | | | | |
| Medifax/EDI | Billing Consultant | | 314 | | | | | |
| Ava Daly | Accounting Fees | | 97 | | | | | |
| Virchow Krause | Accounting Fees | | 9,200 | | | | | |
| Census Solutions (backedout PG5A) | Consultant - Census Program | | 22,500 | | | | | |
| Schmidt Salzman | Tax Consulting | | 275 | | | | | |
| TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.) | | | \$ 396,574 | TOTAL | | \$ | | |

* Attach copy of IMRF notifications

**See instructions.

Alden - Lincoln Park Rehabilitation and Health Care Center, Inc
Legal Fee Support
2008

Pg 21A

| | |
|---|--------------------------|
| Legal Fees Reported on Pg 21, Section C: | 9,524.00 |
| Less: Collection, estates & other non-allowable legal fees listed on Pg 5, Ln 19 | (12,243.00) |
| Less: Non-allowable legal fees, if any, deducted on Pg 5A | <hr/> |
| Allowable Legal Fees | <u><u>(2,719.00)</u></u> |

NOTE:

Legal invoices are not required to be submitted this year because the amount is below \$5,000.

In July, there was a credit of \$7,175 from prior years invoices of Ken Fisch. This was added back on PG 5A.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Il. Health Care Assn. \$3,704
- (3) Did the nursing home make political contributions or payments to a political 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? 7.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,772 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 No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,704
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 benefit: on Schedule V. \$ 21,304 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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. Audit is of the Alden Group, Ltd.
- (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.