



Facility Name & ID Number Alden North Shore Rehab & Health Care Center

# 0042028 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	93	Skilled (SNF)	93	34,038	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	93	TOTALS	93	34,038	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF		2,591	18,177	20,768	8
9	SNF/PED					9
10	ICF	1,041	3,504		4,545	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,041	6,095	18,177	25,313	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.37%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 8/14/99

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 93 and days of care provided 18,177

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 North Shore Rehab & Health Care Ce # 0042028 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
<b>A. General Services</b>											
1	Dietary	520,404	42,397		562,801	1,300	564,101	2,906	567,007		1
2	Food Purchase		297,960		297,960	(33,734)	264,226	(13,674)	250,552		2
3	Housekeeping	121,442	32,749		154,191	1,147	155,338	2,041	157,379		3
4	Laundry	41,357	15,135		56,492	335	56,827		56,827		4
5	Heat and Other Utilities			227,436	227,436		227,436	(3,357)	224,079		5
6	Maintenance	55,597	128	182,560	238,285	221	238,506	30,289	268,795		6
7	Other (specify):* Security&Rel Party							3,149	3,149		7
8	<b>TOTAL General Services</b>	<b>738,800</b>	<b>388,369</b>	<b>409,996</b>	<b>1,537,165</b>	<b>(30,731)</b>	<b>1,506,434</b>	<b>21,354</b>	<b>1,527,788</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			112,000	112,000		112,000		112,000		9
10	Nursing and Medical Records	1,985,972	145,260	3,632	2,134,864	26,323	2,161,187	121,249	2,282,436		10
10a	Therapy	109,803			109,803		109,803		109,803		10a
11	Activities	64,956	3,305	7,115	75,376		75,376		75,376		11
12	Social Services	44,959			44,959		44,959		44,959		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Benef							3,923	3,923		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,205,690</b>	<b>148,565</b>	<b>122,747</b>	<b>2,477,002</b>	<b>26,323</b>	<b>2,503,325</b>	<b>125,172</b>	<b>2,628,497</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	151,360			151,360		151,360	40,105	191,465		17
18	Directors Fees										18
19	Professional Services			892,197	892,197	(19,941)	872,256	(825,891)	46,365		19
20	Dues, Fees, Subscriptions & Promotions			59,962	59,962		59,962	(46,470)	13,492		20
21	Clerical & General Office Expenses	106,306	30,253	104,358	240,917	259	241,176	154,362	395,538		21
22	Employee Benefits & Payroll Taxes			451,790	451,790	23,393	475,183	(432)	474,751		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,542	8,542		8,542	905	9,447		24
25	Other Admin. Staff Transportation			12,496	12,496		12,496	6,129	18,625		25
26	Insurance-Prop.Liab.Malpractice			104,513	104,513	(805)	103,708	8,612	112,320		26
27	Other (specify):* Bad Debt&Relat Party Benef			25,847	25,847		25,847	(981)	24,866		27
28	<b>TOTAL General Administration</b>	<b>257,666</b>	<b>30,253</b>	<b>1,659,705</b>	<b>1,947,624</b>	<b>2,906</b>	<b>1,950,530</b>	<b>(663,661)</b>	<b>1,286,869</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,202,156</b>	<b>567,187</b>	<b>2,192,448</b>	<b>5,961,791</b>	<b>(1,502)</b>	<b>5,960,289</b>	<b>(517,135)</b>	<b>5,443,154</b>		<b>29</b>

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			62,334	62,334		62,334	203,129	265,463			30
31	Amortization of Pre-Op. & Org.			238	238		238		238			31
32	Interest			267,573	267,573	805	268,378	406,031	674,409			32
33	Real Estate Taxes							281,088	281,088			33
34	Rent-Facility & Grounds			986,201	986,201		986,201	(979,451)	6,750			34
35	Rent-Equipment & Vehicles			13,165	13,165		13,165	19,205	32,370			35
36	Other (specify):*							64,571	64,571			36
37	<b>TOTAL Ownership</b>			1,329,511	1,329,511	805	1,330,316	(5,427)	1,324,889			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		897,541	1,651,140	2,548,681	697	2,549,378	(158,660)	2,390,718			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,057	51,057		51,057		51,057			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		897,541	1,702,197	2,599,738	697	2,600,435	(158,660)	2,441,775			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,202,156	1,464,728	5,224,156	9,891,040		9,891,040	(681,222)	9,209,818			45

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

Alden North Shore Rehab & Health Care Center

IDPH Facility ID Number: #0042028

Reclassifications on Pgs 3 & 4 - Column 5

Report Period Beginning: 1/1/2008

Report Period Ending: 12/31/2008

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<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(33,734.00)	Employee Meals
	22	33,734.00	Employee Meals
22		(10,341.00)	Uniforms
	10	7,079.00	Uniforms
	1	1,300.00	Uniforms
	3	1,147.00	Uniforms
	4	335.00	Uniforms
	6	221.00	Uniforms
	11		Uniforms
	21	259.00	Uniforms
26		(805.00)	Interest - old policy/curr yr portion
	32	805.00	Interest - old policy/curr yr portion
26			Interest - new policy/curr yr portion
	32		Interest - new policy/curr yr portion
10		(697.00)	Oxygen - to appropriate cost center
	39	697.00	Oxygen - to appropriate cost center
<u>Others, if any:</u>			
19		(19,940.79)	Reclass to Clinical Coordinators to Line 10
	10	19,940.79	Reclass to Clinical Coordinators to Line 10

Net

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Facility Name & ID Number Alden North Shore Rehab & Health Care Center

# 0042028

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	(177)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,940)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(65,940)	30		9
10	Interest and Other Investment Income	(1,744)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,679)	2		13
14	Non-Care Related Interest	(5,839)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,315)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,355)	20		19
20	Contributions	(8,356)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,267)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,847)	27		24
25	Fund Raising, Advertising and Promotional	(9,767)	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	(213)	20		29
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (140,439)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(466,333)	Various	34
35	Other- Attach Schedule	(74,450)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (540,783)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (681,222)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

## Alden North Shore Rehab &amp; Health Care Center

ID# 0042028

Report Period Beginning: 1/1/08

Ending: 12/31/08

## Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Valet Cost	\$ (43,589)	21	1
2	Late Fees on Utilities	(4,892)	5	2
3	Late Fee on Telephone	(1,149)	21	3
4	Vending Machine Loss	134	2	4
5	Other Nursing Income	(23)	21	5
6	Intercompany Interest Not Allowed	(53,189)	32	6
7				7
8	Miscellaneous Income - Jury Duty Receipt	(128)	21	8
9	Miscellaneous Income - Vending Machine Receipt	(840)	2	9
10	Miscellaneous Income - Food Vendor Rebate	(425)	2	10
11	Miscellaneous Income - Medical Records	(1,514)	10	11
12	Miscellaneous Income-Garnishment Processing	(162)	22	12
13	Back Out 29.31%(2008) of PAC Fees from ILHCA Bills	(1,646)	20	13
14				14
15	Vendor Settlements - Relational Technology Services	(800)	21	15
16	Vendor Settlements - Relational Technology Services	800	6	16
17				17
18	Eliminate Non-Care Employee Benefits	(270)	22	18
19				19
20	Reduce deprec exp on Pg 13 items under \$2,500	(4,499)	30	20
21	Reduce deprec exp on Pg 12 items under \$2,500	(592)	30	21
22	Expense capital itmes > \$2,500 on pg 13 items	31,705	6	22
23	Expense capital itmes > \$2,500 on pg 12 items	8,540	6	23
24	Expense Related Party Items < \$2,500	774	6	24
25				25
26	Back Out Bank Fees - Northshore Associates LLC	(634)	19	26
27				27
28	Eliminate Americans for Job Security	(811)	20	28
29				29
30	Adj for ABC Related Party Profit - Pg 12	(8)	30	30
31	Adj for ABC Related Party Profit - Pg 13	(33)	30	31
32				32
33	Back Out Skokie Chamber of Commerce	(320)	20	33
34				34
35	Back out CPT invoice	(250)	24	35
36				36
37	Deming Related Adj	(630)	24	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(74,450)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden North Shore Rehab &amp; Health Care Center

# 0042028

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	2,906	0	0	0	0	0	0	0	0	2,906	1
2	Food Purchase	(2,987)	0	0	(10,687)	0	0	0	0	0	0	0	(13,674)	2
3	Housekeeping	0	0	2,041	0	0	0	0	0	0	0	0	2,041	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,892)	0	1,535	0	0	0	0	0	0	0	0	(3,357)	5
6	Maintenance	38,880	0	(8,460)	0	0	0	(131)	0	0	0	0	30,289	6
7	Other (specify):*	0	0	2,753	396	0	0	0	0	0	0	0	3,149	7
8	<b>TOTAL General Services</b>	<b>31,001</b>	<b>0</b>	<b>775</b>	<b>(10,291)</b>	<b>0</b>	<b>0</b>	<b>(131)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>21,354</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,514)	0	118,407	3,251	1,105	0	0	0	0	0	0	121,249	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	3,923	0	0	0	0	0	0	0	0	3,923	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,514)</b>	<b>0</b>	<b>122,330</b>	<b>3,251</b>	<b>1,105</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>125,172</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	40,105	0	0	0	0	0	0	0	0	40,105	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,901)	6,134	(819,124)	0	0	0	0	0	0	0	0	(825,891)	19
20	Fees, Subscriptions & Promotions	(22,468)	320	(24,322)	0	0	0	0	0	0	0	0	(46,470)	20
21	Clerical & General Office Expenses	(50,004)	0	121,685	10,702	71,979	0	0	0	0	0	0	154,362	21
22	Employee Benefits & Payroll Taxes	(432)	0	0	0	0	0	0	0	0	0	0	(432)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(880)	0	1,785	0	0	0	0	0	0	0	0	905	24
25	Other Admin. Staff Transportation	0	0	6,129	0	0	0	0	0	0	0	0	6,129	25
26	Insurance-Prop.Liab.Malpractice	0	8,512	100	0	0	0	0	0	0	0	0	8,612	26
27	Other (specify):*	(25,847)	0	24,201	1,137	(472)	0	0	0	0	0	0	(981)	27
28	<b>TOTAL General Administration</b>	<b>(112,532)</b>	<b>14,966</b>	<b>(649,441)</b>	<b>11,839</b>	<b>71,507</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(663,661)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(83,045)</b>	<b>14,966</b>	<b>(526,336)</b>	<b>4,799</b>	<b>72,612</b>	<b>0</b>	<b>(131)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(517,135)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028 Report Period Beginning: 1/1/08 Ending: 12/31/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(71,072)	270,011	2,842	0	1,348	0	0	0	0	0	0	203,129 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(60,772)	433,417	27,864	0	5,522	0	0	0	0	0	0	406,031 32
33	Real Estate Taxes	0	278,472	2,297	0	319	0	0	0	0	0	0	281,088 33
34	Rent-Facility & Grounds	0	(979,451)	0	0	0	0	0	0	0	0	0	(979,451) 34
35	Rent-Equipment & Vehicles	0	0	19,205	0	0	0	0	0	0	0	0	19,205 35
36	Other (specify):*	0	64,571	0	0	0	0	0	0	0	0	0	64,571 36
37	<b>TOTAL Ownership</b>	<b>(131,844)</b>	<b>67,020</b>	<b>52,208</b>	<b>0</b>	<b>7,189</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,427) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(33,869)	(138,015)	13,224	0	0	0	0	0	(158,660) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(33,869)</b>	<b>(138,015)</b>	<b>13,224</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(158,660) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(214,889)</b>	<b>81,986</b>	<b>(474,128)</b>	<b>(29,070)</b>	<b>(58,214)</b>	<b>13,224</b>	<b>(131)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(681,222) 45</b>

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	34 Rent Income	\$ 979,451	Alden North Shore Associates LLC		\$	\$ (979,451) 1
2	V	32 Interest Income - Rr	2,398	Alden North Shore Associates LLC			(2,398) 2
3	V	32 Interest Income - Misc	168,328	Alden North Shore Associates LLC			(168,328) 3
4	V	20 Miscellaneous Income	130	Alden North Shore Associates LLC			(130) 4
5	V	19 Accounting Fees		Alden North Shore Associates LLC		5,500	5,500 5
6	V	19 Bank Charges		Alden North Shore Associates LLC		634	634 6
7	V	20 Dues & Subscriptions		Alden North Shore Associates LLC		450	450 7
8	V	33 Real Estate Tax Expense		Alden North Shore Associates LLC		278,472	278,472 8
9	V	26 Property & Liability Insurance		Alden North Shore Associates LLC		8,512	8,512 9
10	V	36 Mortgage Insurance Premium		Alden North Shore Associates LLC		64,571	64,571 10
11	V	32 Interest - Other		Alden North Shore Associates LLC		596,873	596,873 11
12	V	30 Depreciation Expense		Alden North Shore Associates LLC		270,011	270,011 12
13	V	32 Amortization Expense		Alden North Shore Associates LLC		7,270	7,270 13
14	Total		\$ 1,150,307			\$ 1,232,293	\$ * 81,986 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%	\$ 1,535	\$ 1,535
16	V	24 Travel & Seminar		Alden Management Services, Inc.		1,785	1,785
17	V	25 Other Admin Travel		Alden Management Services, Inc.		6,129	6,129
18	V	26 Insurance		Alden Management Services, Inc.		100	100
19	V	20 Dues/Subscriptions	24,600	Alden Management Services, Inc.		278	(24,322)
20	V	30 Depreciation		Alden Management Services, Inc.		2,842	2,842
21	V	32 Amortization		Alden Management Services, Inc.		31	31
22	V	33 Real Estate Tax		Alden Management Services, Inc.		2,297	2,297
23	V	35 Rent-Equip/Vehic		Alden Management Services, Inc.		19,205	19,205
24	V	32 Interest		Alden Management Services, Inc.		27,833	27,833
25	V	1 Dietary Salary		Alden Management Services, Inc.		2,906	2,906
26	V	3 Housekeeping Salary		Alden Management Services, Inc.		2,041	2,041
27	V	7 Employee Benef-Gen'l Servs		Alden Management Services, Inc.		2,753	2,753
28	V	10 Nurs/Med Rec Salary		Alden Management Services, Inc.		118,407	118,407
29	V	15 Employee Benef-Health Care		Alden Management Services, Inc.		3,923	3,923
30	V	17 Administrative Salary		Alden Management Services, Inc.		40,105	40,105
31	V	27 Employee Benef-Administrative		Alden Management Services, Inc.		24,201	24,201
32	V	19 Professional Fees	839,486	Alden Management Services, Inc.		20,362	(819,124)
33	V	21 Gen'l & Admin		Alden Management Services, Inc.		121,685	121,685
34	V	6 Repair & Mainten.	25,762	Alden Management Services, Inc.		17,302	(8,460)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 889,848			\$ 415,720	\$ * (474,128)

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

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028 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	2 Tube Feeding	\$ 15,348	Prism Health Care Services, Inc.	0.00%	\$ 4,661	\$ (10,687)
16	V	10 Equipment Rental	6,660	Prism Health Care Services, Inc.		9,911	3,251
17	V	39 Supplies	66,240	Prism Health Care Services, Inc.		32,371	(33,869)
18	V	21 Salary G & A		Prism Health Care Services, Inc.		6,430	6,430
19	V	27 Employee Benefits		Prism Health Care Services, Inc.		1,137	1,137
20	V	7 Employee Benefits		Prism Health Care Services, Inc.		396	396
21	V	21 G & A		Prism Health Care Services, Inc.		4,272	4,272
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 88,248			\$ 59,178	\$ * (29,070)

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

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028 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	\$ 427,322	Forum Extended Care Services II, Inc.	0.00%	\$ 621,277	\$ 193,955	15
16	V	39 IV	388,633	Forum Extended Care Services II, Inc.		56,663	(331,970)	16
17	V	39 Wound Care		Forum Extended Care Services II, Inc.				17
18	V	10 House Stock	5,915	Forum Extended Care Services II, Inc.		5,579	(336)	18
19	V	10 Pharmacy Consultant	3,382	Forum Extended Care Services II, Inc.		4,823	1,441	19
20	V	27 Employee Vaccinations	2,330	Forum Extended Care Services II, Inc.		1,858	(472)	20
21	V	21 Employee Benefit: G & A		Forum Extended Care Services II, Inc.		4,722	4,722	21
22	V	21 Salary: G & A		Forum Extended Care Services II, Inc.		40,659	40,659	22
23	V	21 General & Administrative		Forum Extended Care Services II, Inc.		26,598	26,598	23
24	V	32 Interest		Forum Extended Care Services II, Inc.		5,522	5,522	24
25	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		319	319	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		\$ 827,582			\$ 769,368	\$ * (58,214)	39

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

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028 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 Revenue	\$ 1,578,617	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,591,841	\$ 13,224	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		\$ 1,578,617			\$ 1,591,841	\$ *	13,224	39

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

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028 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 & Maintenance	\$ 22,973	Alden Bennett Construction Company, Inc.	0.00%	\$ 22,842	\$ (131)	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		\$ 22,973			\$ 22,842	\$ *	(131)	39

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

Facility Name & ID Number Aiden North Shore Rehab & Health Care Center Provider No. 0042028 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 North Shore Rehab & Health Care Ct # 0042028 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	176,255	2.08	4.91	Salary	\$ 3,745	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	65,806	2.08	4.91	Salary	1,398	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,275	2.08	4.91	Salary	814	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	\$ 5,957		13

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

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

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028 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	\$	25,313	\$ 1,535	1
2	24	Travel/Seminar	patient days*	30	85,812		25,313	1,785	2
3	25	Other Admin Travel	patient days*	30	294,582		25,313	6,129	3
4	26	Insurance	patient days*	30	4,828		25,313	100	4
5	20	Dues/Subscriptions	patient days*	30	13,344		25,313	278	5
6	30	Depreciation	no. of providers	30	98,652		1	2,842	6
7	32	Amortization	patient days*	30	1,500		25,313	31	7
8	33	Real Estate Tax	patient days*	30	125,958		25,313	2,297	8
9	35	Rent-Equip/Vehic	patient days*	30	923,032		25,313	19,205	9
10	32	Interest	patient days*	30	1,783,086		25,313	27,833	10
11	1	Dietary Salary	patient days*	30	139,689	139,689	25,313	2,906	11
12	3	Housekeeping Salary	patient days*	30	98,076	98,076	25,313	2,041	12
13	7	Employee Benef-Gen'l Servs	patient days*	30	130,329		25,313	2,753	13
14	10	Nurs/Med Rec Salary	patient days*	30	1,256,694	1,256,694	25,313	118,407	14
15	15	Employee Benef-Health Care	patient days*	30	188,531		25,313	3,923	15
16	17	Administrative Salary	patient days*	30	2,118,865	2,118,865	25,313	40,105	16
17	27	Employee Benef-Administrative	patient days*	30	1,163,122		25,313	24,201	17
18	19	Professional Fees	patient days*	30	978,599	605,253	25,313	20,362	18
19	21	Gen'l & Admin	patient days*	30	5,848,424	5,104,656	25,313	121,685	19
20	6	Repair & Mainten.	patient days*	30	831,505	644,276	25,313	17,302	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 16,158,399	\$ 9,967,509		\$ 415,720	25

Facility Name & ID Number Alden North Shore Rehab & Health Care Ce # 0042028 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									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Cambridge (GL 2505/7053)		X	Mortgage	\$42,694.00	08/01/05	\$ 8,388,000	\$ 8,098,864	7/31/2045	5.4000	\$ 429,186	1
2	Cambridge(GL 2505-183/7053)		X	Operating Loss Loan	\$16,822.00	08/01/03	3,098,700	2,892,202	8/31/2039	5.6900	167,687	2
3	Bank Leumi (GL 7053)		X	LOC	\$15,000.00	06/01/05	1,084,498		06/01/08	Varies	38,397	3
4	Bank Leumi (GL 2503/7035)		X	LOC		12/12/08	1,081,277	1,081,277	12/11/09	5.0000	2,462	4
5	Insurance Reclass (Interest)		X	Malpractice Insurance							805	5
	<b>Working Capital</b>											
6												6
7	Related Party-AMS		X	Working Capital							27,833	7
8	Related Party-FECII		X	Working Capital							5,522	8
9	TOTAL Facility Related				\$74,516.00		\$ 13,652,475	\$ 12,072,343			\$ 671,892	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income Repl Reserve	X									(3,040)	10
11	Interest Income(4646/4975)	X									(1,744)	11
12	Amortization of Finance Fees										7,301	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 2,517	14
15	TOTALS (line 9+line14)						\$ 13,652,475	\$ 12,072,343			\$ 674,409	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 64,571 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 North Shore Rehab & Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

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

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of total 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 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 Services</u>	<u>\$ 295,853.00</u>	<u>\$ 2,297.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	<u>\$ 28,971.00</u>	<u>\$ 319.00</u>
3. <u>10-28-429-015-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 2,785.65</u>	<u>\$ 2,785.65</u>
4. <u>10-28-429-016-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 2,071.34</u>	<u>\$ 2,071.34</u>
5. <u>10-28-429-017-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 6,545.90</u>	<u>\$ 6,545.90</u>
6. <u>10-28-429-018-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,785.42</u>	<u>\$ 24,785.42</u>
7. <u>10-28-429-019-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,798.21</u>	<u>\$ 24,798.21</u>
8. <u>10-28-429-020-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,617.86</u>	<u>\$ 24,617.86</u>
9. <u>10-28-429-021-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,617.86</u>	<u>\$ 24,617.86</u>
10. <u>10-28-429-022-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,595.83</u>	<u>\$ 24,595.83</u>
	<b>TOTALS</b>	<b>\$ 459,642.07</b>	<b>\$ 137,434.07</b>

**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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 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.

**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 North Shore Rehab & Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

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

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of total 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 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>10-28-429-023-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,573.10</u>	<u>\$ 24,573.10</u>
2. <u>10-28-429-024-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,554.09</u>	<u>\$ 24,554.09</u>
3. <u>10-28-429-025-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,554.09</u>	<u>\$ 24,554.09</u>
4. <u>10-28-429-026-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 24,554.09</u>	<u>\$ 24,554.09</u>
5. <u>10-28-429-027-0000</u>	<u>Nursing Home Facility</u>	<u>\$ 20,018.07</u>	<u>\$ 20,018.07</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ <u>118,253.44</u></b>	<b>\$ <u>118,253.44</u></b>

**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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 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 North Shore Rehab & Health Care Center

# 0042028 Report Period Beginning:

1/1/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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	SNF	34,483	1997	\$ 955,797	1
2					2
3	TOTALS	34,483		\$ 955,797	3

Facility Name & ID Number Alden North Shore Rehab & Health Care Center

# 0042028

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	93	1999	1999	6,782,967	203,542	40	169,574	(33,968)	1,526,166	4
5										5
6										6
7										7
8	Related Party-Forum		1978	14,056		25			14,056	8
	<b>Improvement Type**</b>									
9	draper corp-electric screen		1999	1,252	125	10	125		1,168	9
10	dakota wiring & comm.-wiring for cable tv		1999	2,500	250	10	250		2,313	10
11	climate serv-repair compressor		1999	1,990	133	15	133		1,205	11
12	tcj cable-install cable		1999	1,254	125	10	125		1,148	12
13	ABC-install tiles/repair		2000	4,011	267	15	267		2,361	13
14	ABC-mainten-various/construction		2000	5,000	500	10	500		4,417	14
15	ABC-mainten-various/construction		2000	10,000	1,000	10	1,000		8,750	15
16	ABC-mainten-various/construction		2000	10,000	1,000	10	1,000		8,667	16
17	new horizons-phone system		2000	5,744	574	10	574		5,025	17
18	new horizons-phone system & cablk		2000	2,784	278	10	278		2,412	18
19	new horizons-phone system		2000	3,742	374	10	374		3,242	19
20	dbs contract.-lawn sprinkler system		2000	1,611	107	15	107		912	20
21	ABC-misc construction work		2000	5,347		5			5,347	21
22	ABC-misc construction work		2000	13,118		5			13,118	22
23	ABC-misc construction work (12/31/01 finished-begin exp '02		2001	3,361	336	10	336		2,352	23
24	Laport (walk off mat carpet/floor covering		2001	3,548		5			3,548	24
25	The Floor Source (PT carpet/floor covering		2001	1,576		5			1,576	25
26	ABC-beds/bedside cabinets/washers/dryers/bookcases/wallcover		2001	289,721	19,315	15	19,315		154,519	26
27	New Horizon (phone system)		2001	1,256	126	10	126		901	27
28										28
29										29
30	ABC-misc construction work		2002	16,368	1,091	15	1,091		7,638	30
31	ABC-misc construction work		2003	2,116	212	10	212		1,271	31
32	GT Mechanical-repair exhaust fans		2003	6,080	608	10	608		3,445	32
33	EWS-repair opxyen alarm ssytem		2003	2,054	205	5	205		2,054	33
34	ABC-parking lot upgrades		2003	7,538	753	10	753		4,144	34
35	ABC-parking lot repairs		2003	2,943	293	5	293		2,943	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

## STATE OF ILLINOIS

Facility Name &amp; ID Number Alden North Shore Rehab &amp; Health Care Center

# 0042028

Report Period Beginning:

1/1/08

Ending:

Page 12A

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	GT Mechanical-thermostat equip	2004	\$ 1,693	\$ 169	10	\$ 169	\$	\$ 846	37
38	ABC-repair sewer	2004	19,580	1,958	10	1,958		9,301	38
39	GT Mechanical-misc repairs	2004	1,442	288	5	288		1,345	39
40	GT Mechanical-replace pump	2004	2,496	499	5	499		2,287	40
41	GT Mechanical-misc repairs	2004	614	123	5	123		564	41
42	ABC-bath,plumb. Upgrade	2004	1,813	181	10	181		830	42
43	ABC-painting supplies	2004	1,258	252	5	252		1,133	43
44	GT Mechanical-Electric improvement	2004	917	92	10	92		398	44
45	ABC-plumbing/misc. repairs	2004	3,971	397	10	397		1,687	45
46									46
47	TopNotch-motor drive repair	2004	3,139	314	10	314		1,282	47
48	ABD- carpet repairs	2004	4,943	494	10	494		2,018	48
49	ABC-misc repairs	2004	2,783	398	7	398		1,890	49
50	ABC parking lot improve.	2004	16,008	1,601	10	1,601		6,804	50
51									51
52	ABC-Cabinetry	2005	4,393	293	15	293		915	52
53	Patten CAT-Repair Generator	2005	2,074	104	20	104		389	53
54	GT Mechanical-No AC Water/Temp Low	2005	1,340	134	10	134		357	54
55	GT Mechanical-3 new motors, motor brackets, and fan blades	2005	4,497	450	10	450		1,049	55
56									56
57									57
58	seal/crack/fill asphalt (LLC)	2005	6,045	756	8	756		2,645	58
59	ABC-Patten Repair Generator	2006	2,898	290	10	290		507	59
60	Repaired AC	2006	7,776	778	10	778		1,750	60
61									61
62									62
63									63
64	Repair Water Heater	2007	3,237	324	10	324		621	64
65	New Motors/brackets/fan blades	2007	4,497	899	5	899		1,798	65
66	Replace/Repair Generator	2007	2,898	290	10	290		580	66
67	Second Floor Nurses Station	2007	4,246	425	10	425		850	67
68	Repair Condensor/Fan Motor sensors	2007	2,529	506	5	506		759	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,309,022	\$ 243,227		\$ 209,259	\$ (33,968)	\$ 1,827,304	70

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

STATE OF ILLINOIS

Facility Name & ID Number Alden North Shore Rehab & Health Care Center

# 0042028

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	<b>Totals from Page 12A, Carried Forward</b>	\$ 7,309,022	\$ 243,227		\$ 209,259	\$ (33,968)	\$ 1,827,304		1
2	Installed new alerton controls/rewire/cycling relay	2005 7,064	706	10	706		2,472		2
3	tile and grout restoration-all ceramic tile floors	2005 7,830	783	10	783		2,740		3
4	replaced leaky ceiling parts	2005 1,480	296	5	296		1,036		4
5	fabricate/install elevator finishes/baseboards/etc.	2005 12,843	1,284	10	1,284		4,495		5
6	new hvac motor	2005 3,860	386	10	386		1,190		6
7	wired new electronic starter	2005 1,530	153	10	153		472		7
8	Replaced Domestic Water Pump-ABC	2007 3,032	303	10	303		354		8
9	replaced ambulance bollard-ABC	2007 1,924	481	4	481		521		9
10									10
11	New Asphalt - ABC	2008 2,973	279	8	279		279		11
12	New Asphalt - ABC	2008 4,110	385	8	385		385		12
13	New Fire Alarm Printer/New Ceiling Tiles-ABC	2008 4,007	267	10	267		267		13
14	New Plumbing and Electrical Fixtures-ABC	2008 2,509	139	15	139		139		14
15	New Clear Acrylic-Oakton Glass&Mirror	2008 3,517	264	10	264		264		15
16	New Fire Alarm Annunciator-ABC	2008 2,637	154	10	154		154		16
17	New Belts/New Starter and Coils for Chiller Pump-GT Mech	2008 4,602	153	10	153		153		17
18	General Labor for Atrium-AMS Maintenance Allocation	2008 3,741	125	10	125		125		18
19	New Pump Seals	2008 3,308	110	10	110		110		19
20	New Carpeting/New Overload Startr/New Phase Monitr Str-ABC	2008 4,340	217	5	217		217		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	<b>TOTAL (lines 1 thru 33)</b>	\$ 7,384,330	\$ 249,713		\$ 215,745	\$ (33,968)	\$ 1,842,677		34

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

Facility Name &amp; ID Number Alden North Shore Rehab &amp; Health Care Center

# 0042028

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		\$ 7,384,330	\$ 249,713		\$ 215,745	\$ (33,968)	\$ 1,842,677	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 Remodel	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			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									31
32									32
33	Adj for ABC Related Party Profit	2008	(118)	(8)		(8)		(8)	33
34	TOTAL (lines 1 thru 33)		\$ 7,461,205	\$ 252,361		\$ 218,393	\$ (33,968)	\$ 1,907,949	34

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

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028 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	\$ 552,800	\$ 63,129	\$ 31,157	\$ (31,972)		\$ 383,794	71
72	Current Year Purchases	212,763	14,926	14,926			10,260	72
73	Fully Depreciated Assets	91,024	987	987			91,024	73
74								74
75	TOTALS	\$ 856,587	\$ 79,042	\$ 47,070	\$ (31,972)		\$ 485,078	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)	\$ 9,278,152	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 331,403	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 265,463	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (65,940)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,397,590	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	N/A	\$	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?  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:			\$			3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>			\$			7

10. Effective dates of current rental agreement:  
Beginning 3/1/2000  
Ending 12/31/2029

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

Fiscal Year Ending                      Annual Rent

12.                   /2009    \$ Varies  
13.                   /2010    \$ Varies  
14.                   /2011    \$ Varies

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: \$ 16,723    Description: Copy Machine Lease & Other Office Equipment  
(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>Transport Non-Patients(GL 6890)</u>		\$ <u>521.47</u>	\$ <u>6,258</u>	17
18					18
19	<u>Related Party - AMS</u>	<u>Various</u>	<u>919.42</u>	<u>11,033</u>	19
20					20
21	<b>TOTAL</b>		\$ <u>#####</u>	\$ <u>17,291</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.

**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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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	7	8		
			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	\$		\$	572,248	\$			\$	572,248	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs				33,263					33,263	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-3	hrs				973,106					973,106	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						621,276			621,276	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					13,224		177,601			190,825	13	
14	TOTAL			\$		\$	1,591,841	\$	798,877		\$	2,390,718	14	

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

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

XIV. Special Services (Direct Cost)

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.		
1. OT	39-3	To Col 5	\$0.00	\$572,248.41
2. ST	39-3	To Col 5	0.00	33,262.74
3.				
4. PT	39-3	To Col 5	0.00	973,105.83
5.				
6.				
7.				
8.				
Pharmacy Supplies per GL			0.00	427,321.48
Manual Input from Related Party- Forum Drugs				193,955.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	0.00	<b>621,276.48</b>
10.				
11.				
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00	0.00
Total Exceptional Care (Line 12, Col 8)			0.00	<b>0.00</b>
13. Other:	See Pg 16A			
13. Col 5: Manual Input: Related Party - CPT		To Col 5		<b>13,224.00</b>
Other			0.00	542,741.97
Manual Input: Related Party - Prism				(33,869.00)
Manual Input: Related Party FECII - I.V.				(331,970.00)
Oxygen, from reclass worksheet				698.00
13. Col 6: Supplies Total		To Col 6	0.00	<b>177,600.97</b>
13. Total Line 13, Column 8			0.00	190,824.97
14. Total			0.00	<b>2,390,718.43</b>

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Alden North Shore Rehab &amp; Health Care Center

# 0042028

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*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,000 )	1,054,031	3
4	Supply Inventory (priced at )		4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	1,110	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): Due from 3rd Parties	17,035	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,072,176	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	955,797	13
14	Buildings, at Historical Cost	7,878,133	14
15	Leasehold Improvements, at Historical Cost	501,890	15
16	Equipment, at Historical Cost	243,679	16
17	Accumulated Depreciation (book methods)	(421,527)	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) Refinance Fees	5,463	22
23	Other(specify): Due from Affiliates	1,680,547	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,010,052	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,082,228	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 898,170	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	101,397	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	238,716	30
31	Accrued Taxes Payable (excluding real estate taxes)	44,086	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable	16,633	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	Accr Ins/Exp/Sales Tax/Deferred Rev	49,390	36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,348,392	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,081,278	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44	Shareholder Loans/Others	80,000	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,161,278	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,509,669	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 572,558	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,082,228	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (752,434)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (752,434)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,324,992	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 1,324,992	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 572,558	24 *

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

STATE OF ILLINOIS

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,162,483	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,162,483	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,804	6
7	Oxygen	3,211	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 23,015	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	196	12
13	Barber and Beauty Care	769	13
14	Non-Patient Meals	177	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	496	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,470	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 13,107	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,744	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,744	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Gain on Sale of Assets</b>	12,964	28
28a	See 19A	2,720	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 15,684	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,216,032	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,537,165	31
32	Health Care	2,477,002	32
33	General Administration	1,947,624	33
<b>B. Capital Expense</b>			
34	Ownership	1,329,511	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,548,681	35
36	Provider Participation Fee	51,057	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,891,040	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,324,992	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,324,992	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 &amp; ID Number Alden North Shore Rehab &amp; Health Care Center

# 0042028

Report Period Beginning:

1/1/08

Ending:

12/31/08

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**Details of Page 19, Line 28**

Vending Machine Income	(134.00)
Miscellaneous Income/Medical Records	1,514.10
Miscellaneous Income/Jury Duty	128.20
Miscellaneous Income/Vending Machine	839.66
Miscellaneous Income/Jury Duty/Food Vendor Rebate	425.13
Miscellaneous Income/Garnishment	162.47
Adjustment to Prior Year Expense	(215.79)
	2,719.77

Facility Name & ID Number Alden North Shore Rehab & Health Care Center # 0042028

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	265	265	\$ 8,596	\$ 32.44	1
2	Assistant Director of Nursing	2,094	2,094	74,522	35.59	2
3	Registered Nurses	22,647	24,199	797,668	32.96	3
4	Licensed Practical Nurses	6,942	7,213	186,797	25.90	4
5	CNAs & Orderlies	54,008	56,081	795,292	14.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,080	2,080	29,560	14.21	8
9	Activity Director	1,968	1,968	36,084	18.34	9
10	Activity Assistants	3,014	3,118	28,872	9.26	10
11	Social Service Workers	2,108	2,187	44,958	20.56	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	55,214	26.55	13
14	Head Cook	5,649	5,697	91,043	15.98	14
15	Cook Helpers/Assistants	31,904	33,734	374,147	11.09	15
16	Dishwashers					16
17	Maintenance Workers	2,048	2,080	55,598	26.73	17
18	Housekeepers	11,670	12,560	121,442	9.67	18
19	Laundry	3,782	4,236	41,357	9.76	19
20	Administrator	2,080	2,080	100,067	48.11	20
21	Assistant Administrator	2,080	2,080	51,293	24.66	21
22	Other Administrative	4,171	4,171	132,844	31.85	22
23	Office Manager	2,080	2,080	31,641	15.21	23
24	Clerical	2,656	2,714	22,065	8.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,482	2,491	85,818	34.45	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Unit Director	2,000	2,000	37,278	18.64	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,808	177,208	\$ 3,202,156 *	\$ 18.07	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	\$		35	
36	Medical Director	9333/Monthly	112,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	186/Monthly	2,232	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	285/Monthly	3,096	11-3	44
45	Social Service Consultant	16	528	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	\$ 117,856		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 North Shore Rehab & Health Care Center

# 0042028

Report Period Beginning: 1/1/08

Ending: 12/31/08

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		
Jennifer Illarde	Administrator	0	99,571	Workers' Compensation Insurance	75,738	IDPH License Fee			
Cynthia C. Palao	Assistant Administrator	0	51,789	Unemployment Compensation Insurance	17,836	Advertising: Employee Recruitment	1,425		
				FICA Taxes	241,375	Health Care Worker Background Check	290		
				Employee Health Insurance	92,169	(Indicate # of checks performed <u>29</u> )			
				Employee Meals	33,734	Patient Background Checks	691		
				Illinois Municipal Retirement Fund (IMRF)*		Surety Bond	440		
				Dental/Life Insurance	1,069	ILL Health Care Association	3,450		
				Employee Relations	6,394	Citibank	104		
				Misc Payroll Costs/401K Match	3,818	ATA/EXAM/Sanitation	275		
				Employee Drug Tests/Vaccinations	3,050	Related Party - AMS	598		
				Miscellaneous Income - Garnishment	(162)	Less: Public Relations Expense	( )		
				Eliminate Non-Care Employee Benefits	(270)	Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 151,360	TOTAL (agree to Schedule V, line 22, col.8)		\$ 474,751	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 13,492
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		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Deming Related Adj	(630)	
C. Professional Services							Related Party - AMS	1,785	
Vendor/Payee	Type		Amount				Seminar Expense		
AMS	Management Fees		839,486				Leadership/Deming Training	2,750	
BDO Seidman/Virchow Krause	Accounting Fees		12,650				IHCA/Life Service/ATA/Food&San Cert	3,710	
Ava P. Daley	Accounting Fees		98				Moira Waldron/Itasca CC	1,831	
Bruce Greenburg/AMS Legal	Legal Fees: Non-Collections		500				Entertainment Expense	( )	
Kenneth J Fisch/Ungaretti	Legal Fees: Non-Collections		6,951				(agree to Sch. V, line 24, col. 8)		
Medi.Com	Billing Consultants		304				TOTAL	\$ 9,447	
Kenneth J Fisch/Ungaretti	Legal Fees: Collections		12,267						
Pathway-Reclass to Nursing	Clinical Consulting		19,941						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 892,197	TOTAL		\$			

\* Attach copy of IMRF notifications

\*\*See instructions.



XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Il. Health Care Assn. \$ 3,450
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,629 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. \$ 51,057  
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. \$ 33,734 Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. 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.