



Facility Name & ID Number Alden Springs

# 0047191 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		Skilled (SNF)		0	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	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,253			5,253	13
14	TOTALS	5,253			5,253	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.70%

D. How many bed-hold days during this year were paid by the Department? 561 (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 10/13/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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 Springs # 0047191 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	52,470	2,607		55,077	1,223	56,300	603	56,903		1
2	Food Purchase		49,891		49,891	(2,698)	47,193	(15,637)	31,556		2
3	Housekeeping	10,975	3,866		14,841		14,841	423	15,264		3
4	Laundry		1,512		1,512		1,512		1,512		4
5	Heat and Other Utilities			24,728	24,728		24,728	53	24,781		5
6	Maintenance	2,947	15	44,219	47,181		47,181	(52)	47,129		6
7	Other (specify):* Rel Party							711	711		7
8	<b>TOTAL General Services</b>	<b>66,392</b>	<b>57,891</b>	<b>68,947</b>	<b>193,230</b>	<b>(1,475)</b>	<b>191,755</b>	<b>(13,899)</b>	<b>177,856</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	329,276	19,722	2,902	351,900	996	352,896	5,440	358,336		10
10a	Therapy					5,464		(4,130)	1,334		10a
11	Activities			23,332	23,332		23,332		23,332		11
12	Social Services	39,809			39,809		39,809		39,809		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Benef							814	814		15
16	<b>TOTAL Health Care and Programs</b>	<b>369,085</b>	<b>19,722</b>	<b>29,234</b>	<b>418,041</b>	<b>6,460</b>	<b>424,501</b>	<b>2,124</b>	<b>426,625</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	14,452			14,452		14,452	20,782	35,234		17
18	Directors Fees										18
19	Professional Services			84,314	84,314		84,314	(75,155)	9,159		19
20	Dues, Fees, Subscriptions & Promotions			4,495	4,495		4,495	(2,726)	1,769		20
21	Clerical & General Office Expenses	8,319	1,924	6,830	17,073		17,073	29,616	46,689		21
22	Employee Benefits & Payroll Taxes			64,346	64,346	479	64,825	(6)	64,819		22
23	Inservice Training & Education										23
24	Travel and Seminar			565	565		565	371	936		24
25	Other Admin. Staff Transportation			2,168	2,168		2,168	1,272	3,440		25
26	Insurance-Prop.Liab.Malpractice			19,256	19,256	(139)	19,117	2,076	21,193		26
27	Other (specify):* Bad Debt&Relat Party Benef			5,297	5,297		5,297	74	5,371		27
28	<b>TOTAL General Administration</b>	<b>22,771</b>	<b>1,924</b>	<b>187,271</b>	<b>211,966</b>	<b>340</b>	<b>212,306</b>	<b>(23,696)</b>	<b>188,610</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>458,248</b>	<b>79,537</b>	<b>285,452</b>	<b>823,237</b>	<b>5,325</b>	<b>828,562</b>	<b>(35,471)</b>	<b>793,091</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.

Facility Name &amp; ID Number

Alden Springs

#0047191

Report Period Beginning:

1/1/08

Ending:

12/31/08

## 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			2,391	2,391		2,391	61,918	64,309			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,438	8,438	139	8,577	100,609	109,186			32
33	Real Estate Taxes							3,805	3,805			33
34	Rent-Facility & Grounds			140,679	140,679		140,679	(140,679)				34
35	Rent-Equipment & Vehicles			5,088	5,088		5,088	3,985	9,073			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			156,596	156,596	139	156,735	29,638	186,373			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,746	5,388	20,134	(5,464)	14,670	(3,284)	11,386			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):* Day Training			198,364	198,364		198,364		198,364			43
44	<b>TOTAL Special Cost Centers</b>		14,746	243,720	258,466	(5,464)	253,002	(3,284)	249,718			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	458,248	94,283	685,768	1,238,299		1,238,299	(9,117)	1,229,182			45

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

Alden Springs  
Reclassifications on Pgs 3 & 4 - Column 5

IDPH Facility ID Number: #0047191

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		(2,698.00)	Employee Meals
	22	2,698.00	Employee Meals
22		(2,219.00)	Uniforms
	10	996.00	Uniforms
	1	1,223.00	Uniforms
	3		Uniforms
	4		Uniforms
	6		Uniforms
	11		Uniforms
	21		Uniforms
26		(139.00)	Interest - old policy/curr yr portion
	32	139.00	Interest - old policy/curr yr portion

Others, if any:

DD Providers Only:

39		(5,464.00)	PT, OT, & ST CPT Therapy Costs
	10A	5,464.00	PT, OT, & ST CPT Therapy Costs

Net

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Facility Name & ID Number Alden Springs

# 0047191

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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(40)	21		17
18	Fines and Penalties				18
19	Entertainment	(40)	20		19
20	Contributions	(1,207)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,296)	27		24
25	Fund Raising, Advertising and Promotional	(1,362)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (7,945)		\$	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)	7,903		34
35	Other- Attach Schedule	(9,075)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,172)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (9,117)		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 Springs

ID# 0047191

Report Period Beginning: 1/1/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late Fees on Utilities	\$ (266)	5	1
2	Intercompany Interest Not allowed	(8,250)	32	2
3				3
4	Miscellaneous Income - Food Vendor Rebate	(49)	2	4
5	Miscellaneous Income - Garnishment Processing	(6)	22	5
6				6
7	Back Out 29.31% (for 2008) of PAC Dues	(285)	20	7
8				8
9	Reduce deprec exp on Pg 13 Items under \$2,500	(2,936)	30	9
10	Reduce deprec exp on Pg 12 Items under \$2,500	(42)	30	10
11	Expense capital Items > \$2,500 on Pg 13 items	639	6	11
12	Expense capital Items > \$2,500 on Pg 12 items	0	6	12
13	Expense Related Party Items < \$2,500	774	6	13
14				14
15	Back Out Bank Fees - Trails II LLC	(30)	19	15
16				16
17	Eliminiatue Americans for Job Security	(140)	20	17
18				18
19	Adj Interest Back to Rent	1,516	34	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(9,075)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Springs

# 0047191

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	603	0	0	0	0	0	0	0	0	603	1
2	Food Purchase	(49)	0	0	(15,588)	0	0	0	0	0	0	0	(15,637)	2
3	Housekeeping	0	0	423	0	0	0	0	0	0	0	0	423	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(266)	0	319	0	0	0	0	0	0	0	0	53	5
6	Maintenance	1,413	0	(1,428)	0	0	0	(37)	0	0	0	0	(52)	6
7	Other (specify):*	0	0	571	140	0	0	0	0	0	0	0	711	7
8	<b>TOTAL General Services</b>	<b>1,098</b>	<b>0</b>	<b>488</b>	<b>(15,448)</b>	<b>0</b>	<b>0</b>	<b>(37)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,899)</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	0	0	4,830	176	434	0	0	0	0	0	0	5,440	10
10a	Therapy	0	0	0	0	0	(4,130)	0	0	0	0	0	(4,130)	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	814	0	0	0	0	0	0	0	0	814	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>5,644</b>	<b>176</b>	<b>434</b>	<b>(4,130)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,124</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	20,782	0	0	0	0	0	0	0	0	20,782	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(30)	30	(75,155)	0	0	0	0	0	0	0	0	(75,155)	19
20	Fees, Subscriptions & Promotions	(3,034)	250	58	0	0	0	0	0	0	0	0	(2,726)	20
21	Clerical & General Office Expenses	(40)	0	25,252	3,767	637	0	0	0	0	0	0	29,616	21
22	Employee Benefits & Payroll Taxes	(6)	0	0	0	0	0	0	0	0	0	0	(6)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	371	0	0	0	0	0	0	0	0	371	24
25	Other Admin. Staff Transportation	0	0	1,272	0	0	0	0	0	0	0	0	1,272	25
26	Insurance-Prop.Liab.Malpractice	0	2,055	21	0	0	0	0	0	0	0	0	2,076	26
27	Other (specify):*	(5,296)	0	5,022	400	(52)	0	0	0	0	0	0	74	27
28	<b>TOTAL General Administration</b>	<b>(8,406)</b>	<b>2,335</b>	<b>(22,377)</b>	<b>4,167</b>	<b>585</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(23,696)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(7,308)</b>	<b>2,335</b>	<b>(16,245)</b>	<b>(11,105)</b>	<b>1,019</b>	<b>(4,130)</b>	<b>(37)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(35,471)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Springs

# 0047191

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	(2,978)	60,706	2,842	0	1,348	0	0	0	0	0	0	61,918	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,250)	98,535	10,272	0	52	0	0	0	0	0	0	100,609	32
33	Real Estate Taxes	0	3,325	477	0	3	0	0	0	0	0	0	3,805	33
34	Rent-Facility & Grounds	1,516	(142,195)	0	0	0	0	0	0	0	0	0	(140,679)	34
35	Rent-Equipment & Vehicles	0	0	3,985	0	0	0	0	0	0	0	0	3,985	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(9,712)</b>	<b>20,371</b>	<b>17,576</b>	<b>0</b>	<b>1,403</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>29,638</b>	<b>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	(4,547)	1,263	0	0	0	0	0	0	(3,284)	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>(4,547)</b>	<b>1,263</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,284)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(17,020)</b>	<b>22,706</b>	<b>1,331</b>	<b>(15,652)</b>	<b>3,685</b>	<b>(4,130)</b>	<b>(37)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,117)</b>	<b>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	\$ 142,195	Alden Trails II, LLC		\$	\$ (142,195) 1
2	V	19 Bank Charges		Alden Trails II, LLC		30	30 2
3	V	20 Dues & Subscriptions		Alden Trails II, LLC		250	250 3
4	V	33 Real Estate Tax Expense		Alden Trails II, LLC		3,325	3,325 4
5	V	26 General Insurance Expense		Alden Trails II, LLC		2,055	2,055 5
6	V	32 Interest - Harris		Alden Trails II, LLC		92,340	92,340 6
7	V	32 Interest - Other		Alden Trails II, LLC		6,195	6,195 7
8	V	30 Depreciation		Alden Trails II, LLC		60,706	60,706 8
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 142,195			\$ 164,901	\$ * 22,706 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%	\$ 319	\$ 319	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		371	371	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,272	1,272	17
18	V	26 Insurance		Alden Management Services, Inc.		21	21	18
19	V	20 Dues/Subscriptions		Alden Management Services, Inc.		58	58	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,842	2,842	20
21	V	32 Amortization		Alden Management Services, Inc.		6	6	21
22	V	33 Real Estate Tax		Alden Management Services, Inc.		477	477	22
23	V	35 Rent-Equip/Vehic		Alden Management Services, Inc.		3,985	3,985	23
24	V	32 Interest		Alden Management Services, Inc.		10,266	10,266	24
25	V	1 Dietary Salary		Alden Management Services, Inc.		603	603	25
26	V	3 Housekeeping Salary		Alden Management Services, Inc.		423	423	26
27	V	7 Employee Benef-Gen'l Servs		Alden Management Services, Inc.		571	571	27
28	V	10 Nurs/Med Rec Salary		Alden Management Services, Inc.		4,830	4,830	28
29	V	15 Employee Benef-Health Care		Alden Management Services, Inc.		814	814	29
30	V	17 Administrative Salary		Alden Management Services, Inc.		20,782	20,782	30
31	V	27 Employee Benef-Administrative		Alden Management Services, Inc.		5,022	5,022	31
32	V	19 Professional Fees	79,380	Alden Management Services, Inc.		4,225	(75,155)	32
33	V	21 Gen'l & Admin		Alden Management Services, Inc.		25,252	25,252	33
34	V	6 Repair & Mainten.	5,019	Alden Management Services, Inc.		3,591	(1,428)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 84,399			\$ 85,730	\$ * 1,331	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Tube Feeding	\$ 21,217	Prism Health Care Services, Inc.	0.00%	\$ 5,629	\$ (15,588)
16	V	10 Equipment Rental	360	Prism Health Care Services, Inc.		536	176
17	V	39 Supplies	9,488	Prism Health Care Services, Inc.		4,941	(4,547)
18	V	21 Salary G & A		Prism Health Care Services, Inc.		2,264	2,264
19	V	27 Employee Benefits		Prism Health Care Services, Inc.		400	400
20	V	7 Employee Benefits		Prism Health Care Services, Inc.		140	140
21	V	21 G & A		Prism Health Care Services, Inc.		1,503	1,503
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		\$ 31,065			\$ 15,413	\$ * (15,652)

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

Facility Name & ID Number Alden Springs # 0047191 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	\$ 3,547	Forum Extended Care Services II, Inc.	0.00%	\$ 5,157	\$ 1,610	15
16	V	39 IV		Forum Extended Care Services II, Inc.				16
17	V	39 Wound Care	1,711	Forum Extended Care Services II, Inc.		1,364	(347)	17
18	V	10 House Stock	952	Forum Extended Care Services II, Inc.		898	(54)	18
19	V	10 Pharmacy Consultant	1,146	Forum Extended Care Services II, Inc.		1,634	488	19
20	V	27 Employee Vaccinations	480	Forum Extended Care Services II, Inc.		383	(97)	20
21	V	27 Employee Benefit: G & A		Forum Extended Care Services II, Inc.		45	45	21
22	V	21 Salary: G & A		Forum Extended Care Services II, Inc.		385	385	22
23	V	21 General & Administrative		Forum Extended Care Services II, Inc.		252	252	23
24	V	32 Interest		Forum Extended Care Services II, Inc.		52	52	24
25	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		3	3	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		\$ 7,836			\$ 11,521	\$ * 3,685	39

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

Facility Name & ID Number Alden Springs # 0047191 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	10a Therapy Reevenue	\$ 5,464	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,334	\$ (4,130)	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		\$ 5,464			\$ 1,334	\$ * (4,130)	39

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

Facility Name & ID Number Alden Springs # 0047191 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	\$ 6,571	Alden Bennett Construction Company, Inc.	0.00%	\$ 6,534	\$ (37)	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		\$ 6,571			\$ 6,534	\$ * (37)	39

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

STATE OF ILLINIOS

Facility Name & ID Number Alden Springs

Provider No. 0047191

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

Facility Name & ID Number Alden Springs # 0047191 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	179,223	17.2	0.43	Salary	\$ 777	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	66,915	17.2	0.43	Salary	290	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,930	17.2	0.43	Salary	169	6-7	3
4											4
5											5
6	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is the Director of Clinical Services and provides technical support for the entire nursing staff.										7
8	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry coordinates the purchase of all building maintenance items as well as supervise building engineers.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,236		13

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

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

Facility Name & ID Number Alden Springs

# 0047191 Report Period Beginning: 1/1/08

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	\$	5,253	\$ 319	1
2	24	Travel/Seminar	patient days*	30	85,812		5,253	371	2
3	25	Other Admin Travel	patient days*	30	294,582		5,253	1,272	3
4	26	Insurance	patient days*	30	4,828		5,253	21	4
5	20	Dues/Subscriptions	patient days*	30	13,344		5,253	58	5
6	30	Depreciation	no. of providers	30	98,652		1	2,842	6
7	31	Amortization	patient days*	30	1,500		5,253	6	7
8	33	Real Estate Tax	patient days*	30	125,958		5,253	477	8
9	35	Rent-Equip/Vehic	patient days*	30	923,032		5,253	3,985	9
10	32	Interest	patient days*	30	1,783,086		5,253	10,266	10
11	1	Dietary Salary	patient days*	30	139,689	139,689	5,253	603	11
12	3	Housekeeping Salary	patient days*	30	98,076	98,076	5,253	423	12
13	7	Employee Benef-Gen'l Servs	patient days*	30	132,325		5,253	571	13
14	10	Nurs/Med Rec Salary	patient days*	30	1,256,694	1,256,694	5,253	4,830	14
15	15	Employee Benef-Health Care	patient days*	30	188,531		5,253	814	15
16	17	Administrative Salary	patient days*	30	2,118,865	2,118,865	5,253	20,782	16
17	27	Employee Benef-Administrative	patient days*	30	1,163,122		5,253	5,022	17
18	19	Professional Fees	patient days*	30	978,599	605,253	5,253	4,225	18
19	21	Gen'l & Admin	patient days*	30	5,848,424	5,104,656	5,253	25,252	19
20	6	Repair & Mainten.	patient days*	30	831,505	644,276	5,253	3,591	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 16,160,395	\$ 9,967,509		\$ 85,730	25

Facility Name & ID Number Alden Springs # 0047191 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	Harris (GI 2512/7044)		X	Mortgage	\$10,752.46	12/1/06	\$ 1,781,000	\$ 1,670,247	11/01/2011	5.2500	\$ 92,340	1
2												2
3												3
4												4
5	Insurance Reclass (Interest)		X	Malpractice Insurance							139	5
	<b>Working Capital</b>											
6												6
7	Related Party-AMS		X	Working Capital							10,266	7
8	Related Party-FECII		X	Working Capital							52	8
9	<b>TOTAL Facility Related</b>				\$10,752.46		\$ 1,781,000	\$ 1,670,247			\$ 102,797	9
	<b>B. Non-Facility Related*</b>											
10	AFCO Interest(GL 7053)		X								6,195	10
11												11
12	ANI Interest (\$31.40)		X								188	12
13	Amortization of Financing Fees										6	13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 6,389	14
15	<b>TOTALS (line 9+line14)</b>						\$ 1,781,000	\$ 1,670,247			\$ 109,186	15

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

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Springs COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0047191

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

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

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

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

(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <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>\$ 478.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	<u>\$ 28,917.00</u>	<u>\$ 3.00</u>
3. <u>02-23-300-024</u>	<u>Nursing Home Facility</u>	<u>\$ 3,524.70</u>	<u>\$ 3,524.70</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ <u>328,294.70</u></b>	<b>\$ <u>4,005.70</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 &amp; ID Number Alden Springs

# 0047191

Report Period Beginning:

1/1/08

Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 7,150 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories OneC. 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)

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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	Building	22,035		\$ 398,630	1
2					2
3	TOTALS	22,035		\$ 398,630	3

Facility Name & ID Number Alden Springs

# 0047191

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	16		2006	\$ 1,583,599	\$ 39,590	40	\$ 39,590		\$ 89,077
5			2006	69,510	1,738	40	1,738		3,910
6			2006	20,156	504	40	504		1,344
7									
8	Related Party-Forum		1978	14,056		25			14,056
	Improvement Type**								
9	Wiring		2006	840	42	20	42		95
10									
11	Drywall Carpentry		2007	18,677	1,245	15	1,245		2,075
12	Plumb, Floor Prep, Fencing-ABC Renovation		2007	23,127	2,313	10	2,313		4,626
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
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

Facility Name &amp; ID Number Alden Springs

# 0047191

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 12C, Carried Forward</b>		\$ 1,729,966	\$ 45,432		\$ 45,432	\$	\$ 115,183	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 Improvemen	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		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									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,806,959	\$ 48,087		\$ 48,087	\$	\$ 180,695	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 163,559	\$ 16,099	\$ 16,099	\$		\$ 44,303	71
72	Current Year Purchases	855	54	54			95	72
73	Fully Depreciated Assets	60,758	69	69			60,758	73
74								74
75	TOTALS	\$ 225,172	\$ 16,222	\$ 16,222	\$		\$ 105,156	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	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	2,435,324	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	64,309	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	64,309	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)	\$	290,414	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

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

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

10. Effective dates of current rental agreement:  
 Beginning 1/1/07  
 Ending 11/1/2011

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

Fiscal Year Ending                      Annual Rent

12.                      /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: \$ 5,088 Description: Copy Machine Lease  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19	<u>Related Party - AMS</u>	<u>Various</u>	<u>147.25</u>	<u>2,290</u>	19
20					20
21	<b>TOTAL</b>		\$ <u>147.25</u>	\$ <u>2,290</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 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Units	Cost	Total Cost (Col. 3 + 5 + 6)					
1	Licensed Occupational Therapist	39-3	hrs	\$									\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	39-3	hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	See Pg 16A	# of prescripts							5,157			5,157	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								6,229			6,229	13
14	TOTAL			\$				\$		\$ 11,386			\$ 11,386	14

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

XIV. Special Services (Direct Cost)

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.		
1. OT	39-3	To Col 5	\$0.00	\$897.95
2. ST	39-3	To Col 5	0.00	1,094.82
3.				
4. PT	39-3	To Col 5	0.00	3,471.49
5.				
6.				
7.				
8.				
Pharmacy Supplies per GL			0.00	3,546.77
Manual Input from Related Party- Forum Drugs				1,610.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	0.00	5,156.77
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	0.00
13. Other:	See Pg 16A			
13. Col 5: Manual Input: Related Party - CPT		To Col 5		
Other			0.00	11,123.33
Manual Input: Related Party - Prism				(4,547.00)
Manual Input: Related Party FECII - I.V.				
Manual Input: Related Party Wound Care				(347.00)
Oxygen, from reclass worksheet				
13. Col 6: Supplies Total		To Col 6	0.00	6,229.33
13. Total Line 13, Column 8			0.00	6,229.33
14. Total			0.00	16,850.36

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Alden Springs

# 0047191

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 (3,600) )	312,264	3
4	Supply Inventory (priced at )		4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	4,575	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 316,839	10
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	398,630	13
14	Buildings, at Historical Cost	1,674,106	14
15	Leasehold Improvements, at Historical Cost	18,677	15
16	Equipment, at Historical Cost	6,768	16
17	Accumulated Depreciation (book methods)	(4,639)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 20,806	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 337,645	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 222,354	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	1,231	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	26,881	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,600	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	Accr Ins,EXPS,IDPA,Sales Tax, Etc	1,066	36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 258,132	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43	Due to Affiliates	269,536	43
44	Shareholder Loans/Others		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 269,536	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 527,668	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (190,023)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 337,645	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (324,261)	1
2	Restatements (describe):		2
3	External Audit Adjustment made after 2007 cost report	41,664	3
4	was submitted. These have no effect on prior year's report:		4
5	Bad Debt, Medicare Revenues (Non-Allowables)		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (282,597)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	92,574	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)	\$ 92,574	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (190,023)	24 *

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs

# 0047191

Report Period Beginning: 1/1/08

Ending:

Page 19  
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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,147,077	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,147,077	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Page 19A</u>	183,796	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 183,796	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,330,873	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	193,230	31
32	Health Care	418,041	32
33	General Administration	211,966	33
<b>B. Capital Expense</b>			
34	Ownership	156,596	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	218,498	35
36	Provider Participation Fee	39,968	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,238,299	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	92,574	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 92,574	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.

**Details of Page 19, Line 28**

Late Fee Charge	(30.00)
Miscellaneous Income-Food Vendor Rebate	48.89
Miscellaneous Income-Garnishment	6.00
Day Training Income	183,771.01
	<b>183,795.90</b>

Facility Name & ID Number Alden Springs

# 0047191

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			\$	\$	1
2					2
3	231	231	6,532	28.28	3
4	2,394	2,525	65,734	26.03	4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13	130	130	2,491	19.16	13
14	4,160	4,160	48,545	11.67	14
15	129	129	1,434	11.12	15
16					16
17	130	130	2,947	22.67	17
18	1,150	1,150	10,975	9.54	18
19					19
20	520	520	14,452	27.79	20
21					21
22	227	227	8,319	36.65	22
23					23
24					24
25					25
26					26
27					27
28	2,080	2,080	39,809	19.14	28
29					29
30	21,359	22,398	257,010	11.47	30
31					31
32					32
33					33
34	32,510	33,680	\$ 458,248 *	\$ 13.61	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		\$		35
36	\$250/Monthly	3,000	10-3	36
37				37
38				38
39	\$32/Monthly	384	10-3	39
40				40
41				41
42				42
43				43
44	430	23,002	11-3	44
45	5	330	11-3	45
46				46
47				47
48				48
49	435	\$ 26,716		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53





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. \$ 883
- (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. \$ 5,678 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. \$ 39,968  
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. \$ 2,698 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.