

Facility Name & ID Number Alden Village North

0049122 Report Period Beginning: 1/3/08 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	150	Skilled Pediatric (SNF/PED)	150	54,600	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	150	TOTALS	150	54,600	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED	32,882	489		33,371
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	32,882	489		33,371

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.12%

D. How many bed-hold days during this year were paid by the Department? 1,284 (Do not include bed-hold days in Section B.)

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

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

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

YES NO

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

YES NO

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

Date started 1/3/08

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

YES Date 1/3/08 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 _____

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.

Facility Name & ID Number Alden Village North # 0049122 Report Period Beginning: 1/3/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	243,885	20,556	10,800	275,241	5,276	280,517	2,080	282,597		1
2	Food Purchase		483,293		483,293	(24,827)	458,466	(240,586)	217,880		2
3	Housekeeping	134,830	58,467		193,297	4,692	197,989	2,690	200,679		3
4	Laundry	118,977	24,332		143,309		143,309		143,309		4
5	Heat and Other Utilities			170,343	170,343		170,343	(506)	169,837		5
6	Maintenance	43,614		147,435	191,049		191,049	(42,994)	148,055		6
7	Other (specify):* Related Party							6,032	6,032		7
8	TOTAL General Services	541,306	586,648	328,578	1,456,532	(14,859)	1,441,673	(273,284)	1,168,389		8
	B. Health Care and Programs										
9	Medical Director			60,100	60,100		60,100		60,100		9
10	Nursing and Medical Records	2,222,903	201,269	4,428	2,428,600	2,745	2,431,345	35,041	2,466,386		10
10a	Therapy					779,789	779,789	40,191	819,980		10a
11	Activities	37,743	4,422	179,840	222,005		222,005		222,005		11
12	Social Services	86,138			86,138		86,138		86,138		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party							5,171	5,171		15
16	TOTAL Health Care and Programs	2,346,784	205,691	244,368	2,796,843	782,534	3,579,377	80,403	3,659,780		16
	C. General Administration										
17	Administrative	59,010			59,010		59,010	98,079	157,089		17
18	Directors Fees										18
19	Professional Services			396,972	396,972	(500)	396,472	(347,960)	48,512		19
20	Dues, Fees, Subscriptions & Promotions			32,977	32,977		32,977	(16,272)	16,705		20
21	Clerical & General Office Expenses	188,287	29,264	64,585	282,136	1,376	283,512	203,753	487,265		21
22	Employee Benefits & Payroll Taxes			543,492	543,492	11,238	554,730	(166)	554,564		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,877	3,877		3,877	2,354	6,231		24
25	Other Admin. Staff Transportation			265	265		265	8,080	8,345		25
26	Insurance-Prop.Liab.Malpractice			163,870	163,870	(1,129)	162,741	132	162,873		26
27	Other (specify):* Related Party			13,066	13,066		13,066	25,585	38,651		27
28	TOTAL General Administration	247,297	29,264	1,219,104	1,495,665	10,985	1,506,650	(26,415)	1,480,235		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,135,387	821,603	1,792,050	5,749,040	778,660	6,527,700	(219,296)	6,308,404		29

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

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

Facility Name & ID Number Alden Village North #0049122 Report Period Beginning: 1/3/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			17,643	17,643		17,643	147,011	164,654		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			138,181	138,181	1,129	139,310	394,044	533,354		32
33	Real Estate Taxes			103,108	103,108	(103,108)		106,143	106,143		33
34	Rent-Facility & Grounds			329,785	329,785	103,108	432,893	(432,893)			34
35	Rent-Equipment & Vehicles			4,209	4,209		4,209	25,319	29,528		35
36	Other (specify):*										36
37	TOTAL Ownership			592,926	592,926	1,129	594,055	239,624	833,679		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	55,417	198,743	779,889	1,034,049	(779,789)	254,260	(34,786)	219,474		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			411,514	411,514		411,514		411,514		42
43	Other (specify):* Day Training Costs			529,268	529,268		529,268		529,268		43
44	TOTAL Special Cost Centers	55,417	198,743	1,720,671	1,974,831	(779,789)	1,195,042	(34,786)	1,160,256		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,190,804	1,020,346	4,105,647	8,316,797		8,316,797	(14,458)	8,302,339		45

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

Alden Village North

IDPH Facility ID Number: #0049122

Reclassifications on Pgs 3 & 4 - Column 5

Report Period Beginning: 1/1/2008

Report Period Ending: 12/31/2008

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(24,827.00)	Employee Meals
	22	24,827.00	Employee Meals
22		(13,589.00)	Uniforms
	10	2,745.00	Uniforms
	1	5,276.00	Uniforms
	3	4,692.00	Uniforms
	4		Uniforms
	6		Uniforms
	11		Uniforms
	21	876.00	Uniforms
26		(1,000.00)	Interest - old policy/curr yr portion
	32	1,000.00	Interest - old policy/curr yr portion
33		(103,108.00)	Rent classified as Real Estate Tax on Operator
	34	103,108.00	Rent classified as Real Estate Tax on Operator
<u>Others, if any:</u>			
26		(129.00)	Insurance Financing Fees
	32	129.00	Insurance Financing Fees
19		(500.00)	Prepay misc court expense (AMS Legal)
	21	500.00	Prepay misc court expense (AMS Legal)
<u>DD Providers Only:</u>			
39		(779,789.00)	PT, OT, ST, & RT CPT Therapy Costs
	10A	779,789.00	PT, OT, ST, & RT CPT Therapy Costs
Net		<hr/>	-

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning: 1/3/08

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	(207)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(12,806)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,513)	20		19
20	Contributions	(6,218)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,050)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,066)	27		24
25	Fund Raising, Advertising and Promotional	(5,597)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,457)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	7,775	Various	34
35	Other- Attach Schedule	18,224	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 25,999		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (14,458)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Alden Village North

ID# 0049122

Report Period Beginning: 1/3/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Expense items < \$2,500 related to Pg 12 (curr yr)	\$ 13,440	6	1
2	Expense items < \$2,500 related to Pg 13 (curr yr)	31,369	6	2
3	Elim expense on items < \$2,500 related to Pg 12	(1,426)	30	3
4	Elim expense on items < \$2,500 related to Pg 13	(2,228)	30	4
5	Late Fees - Utilities	(2,530)	5	5
6	Misc Income - Record Copies	(20)	10	6
7	Misc Income - Jury Duty	(34)	21	7
8	Misc Income - Food Rebate	(238)	2	8
9	Misc Income - Wage Service Fees	(166)	22	9
10	Marketing Manager Salaries	(13,387)	21	10
11	Back out late fee interest on partnership	(2,449)	32	11
12	Eliminate unspecified legal deposit	(500)	19	12
13	PAC Fee - Americans For Job Security	(1,310)	20	13
14	PAC Fee - Alliance for Quality Nursing	(2,250)	20	14
15	Adj for ABC Related Party Profit-Pg 12	(16)	30	15
16	Adj for ABC Related Party Profit-Pg 13	(31)	30	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	18,224		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning:

1/3/08

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)	
	A. General Services													
1	Dietary	0	0	3,832	(1,752)	0	0	0	0	0	0	0	2,080	1
2	Food Purchase	(445)	0	0	(240,141)	0	0	0	0	0	0	0	(240,586)	2
3	Housekeeping	0	0	2,690	0	0	0	0	0	0	0	0	2,690	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,530)	0	2,024	0	0	0	0	0	0	0	0	(506)	5
6	Maintenance	44,809	0	(87,611)	0	0	0	(192)	0	0	0	0	(42,994)	6
7	Other (specify):*	0	0	3,630	2,402	0	0	0	0	0	0	0	6,032	7
8	TOTAL General Services	41,834	0	(75,435)	(239,491)	0	0	(192)	0	0	0	0	(273,284)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20)	0	30,686	3,251	1,124	0	0	0	0	0	0	35,041	10
10a	Therapy	0	0	0	0	0	40,191	0	0	0	0	0	40,191	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	5,171	0	0	0	0	0	0	0	0	5,171	15
16	TOTAL Health Care and Programs	(20)	0	35,857	3,251	1,124	40,191	0	0	0	0	0	80,403	16
	C. General Administration													
17	Administrative	0	44	98,035	0	0	0	0	0	0	0	0	98,079	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,550)	6,200	(352,610)	0	0	0	0	0	0	0	0	(347,960)	19
20	Fees, Subscriptions & Promotions	(16,888)	250	366	0	0	0	0	0	0	0	0	(16,272)	20
21	Clerical & General Office Expenses	(26,227)	3,314	160,422	64,844	1,400	0	0	0	0	0	0	203,753	21
22	Employee Benefits & Payroll Taxes	(166)	0	0	0	0	0	0	0	0	0	0	(166)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,354	0	0	0	0	0	0	0	0	2,354	24
25	Other Admin. Staff Transportation	0	0	8,080	0	0	0	0	0	0	0	0	8,080	25
26	Insurance-Prop.Liab.Malpractice	0	0	132	0	0	0	0	0	0	0	0	132	26
27	Other (specify):*	(13,066)	0	31,904	6,892	(145)	0	0	0	0	0	0	25,585	27
28	TOTAL General Administration	(57,897)	9,808	(51,317)	71,736	1,255	0	0	0	0	0	0	(26,415)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,083)	9,808	(90,895)	(164,504)	2,379	40,191	(192)	0	0	0	0	(219,296)	29

STATE OF ILLINOIS

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning:

1/3/08

Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3,701)	146,522	2,842	0	1,348	0	0	0	0	0	0	147,011	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,449)	331,125	65,253	0	115	0	0	0	0	0	0	394,044	32
33	Real Estate Taxes	0	103,108	3,028	0	7	0	0	0	0	0	0	106,143	33
34	Rent-Facility & Grounds	0	(432,893)	0	0	0	0	0	0	0	0	0	(432,893)	34
35	Rent-Equipment & Vehicles	0	0	25,319	0	0	0	0	0	0	0	0	25,319	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,150)	147,862	96,442	0	1,470	0	0	0	0	0	0	239,624	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(37,141)	2,355	0	0	0	0	0	0	(34,786)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(37,141)	2,355	0	0	0	0	0	0	(34,786)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(22,233)	157,670	5,547	(201,645)	6,204	40,191	(192)	0	0	0	0	(14,458)	45

VII. RELATED PARTIES

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

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

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	\$ 432,893	Alden Village North II, LLC	100.00%	\$	\$ (432,893)	1
2	V	17 Administrative		Alden Village North II, LLC		44	44	2
3	V	19 Accounting Fee		Alden Village North II, LLC		6,200	6,200	3
4	V	33 Real Estate Tax		Alden Village North II, LLC		103,108	103,108	4
5	V	20 Dues & Subscriptions		Alden Village North II, LLC		250	250	5
6	V	32 Interest On Mortg. Note		Alden Village North II, LLC		317,676	317,676	6
7	V	36 Mortgage Insurance Premium		Alden Village North II, LLC				7
8	V	30 Depreciation		Alden Village North II, LLC		146,522	146,522	8
9	V	32 Amortization		Alden Village North II, LLC		11,000	11,000	9
10	V	21 General Insurance expense		Alden Village North II, LLC		3,314	3,314	10
11	V	21 Bank Fees		Alden Village North II, LLC				11
12	V	32 Interest -Other		Alden Village North II, LLC		2,449	2,449	12
13	V							13
14	Total		\$ 432,893			\$ 590,563	\$ * 157,670	14

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

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning: 1/3/08

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	5 Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 2,024	\$ 2,024	15
16	V	24 Trav & Seminar		Alden Management Services, Inc.		2,354	2,354	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		8,080	8,080	17
18	V	26 Insurance		Alden Management Services, Inc.		132	132	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		366	366	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,842	2,842	20
21	V	32 Amortization		Alden Management Services, Inc.		41	41	21
22	V	33 Real Estate Tax		Alden Management Services, Inc.		3,028	3,028	22
23	V	35 Rent -Equip & Vehicles		Alden Management Services, Inc.		25,319	25,319	23
24	V	32 Interest		Alden Management Services, Inc.		65,212	65,212	24
25	V	1 Dietary		Alden Management Services, Inc.		3,832	3,832	25
26	V	3 Housekeeping		Alden Management Services, Inc.		2,690	2,690	26
27	V	7 Employee Benefits -Gen'L Servs		Alden Management Services, Inc.		3,630	3,630	27
28	V	10 Nurs & Med Records Salary		Alden Management Services, Inc.		30,686	30,686	28
29	V	15 Employee Benefits -Health Care		Alden Management Services, Inc.		5,171	5,171	29
30	V	17 Administrative Salary		Alden Management Services, Inc.		98,035	98,035	30
31	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		31,904	31,904	31
32	V	19 Professional Fees	379,453	Alden Management Services, Inc.		26,843	(352,610)	32
33	V	21 Gen'I & Admin		Alden Management Services, Inc.		160,422	160,422	33
34	V	6 Repair & Maint.	110,419	Alden Management Services, Inc.		22,808	(87,611)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 489,872			\$ 495,419	\$ * 5,547	39

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

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning: 1/3/08

Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	Diet. Consultant	\$ 10,800	Prism Health Care Services, Inc.	0.00%	\$ 2,733	\$ (8,067)	15
16	V	1	Dietarty Salary		Prism Health Care Services, Inc.		6,315	6,315	16
17	V	2	Tube Feeding	335,684	Prism Health Care Services, Inc.		95,543	(240,141)	17
18	V	10	Equip. Rental	6,660	Prism Health Care Services, Inc.		9,911	3,251	18
19	V	39	Ancillary Supplies	181,599	Prism Health Care Services, Inc.		93,351	(88,248)	19
20	V	39	Vent Rental		Prism Health Care Services, Inc.		51,107	51,107	20
21	V	21	Gen'L & Admin Salary		Prism Health Care Services, Inc.		38,964	38,964	21
22	V	27	Employee Benefits		Prism Health Care Services, Inc.		6,892	6,892	22
23	V	7	Employee Benefits		Prism Health Care Services, Inc.		2,402	2,402	23
24	V	21	Gen'l & Admin				25,880	25,880	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		\$ 534,743				\$ 333,098	\$ * (201,645)	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	39 Drugs	\$ 5,964	Forum Extended Care Services II, Inc.	0.00%	\$ 8,671	\$ 2,707	15
16	V	39 IV		Forum Extended Care Services II, Inc.				16
17	V	39 Wound Care	1,736	Forum Extended Care Services II, Inc.		1,384	(352)	17
18	V	10 House Stock	5,014	Forum Extended Care Services II, Inc.		4,729	(285)	18
19	V	10 Pharmacy Consultant	3,308	Forum Extended Care Services II, Inc.		4,717	1,409	19
20	V	27 Employee Vaccin.	1,201	Forum Extended Care Services II, Inc.		958	(243)	20
21	V	27 Employee Benefits: G&A		Forum Extended Care Services II, Inc.		98	98	21
22	V	21 Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		846	846	22
23	V	21 Gen'l & Admin		Forum Extended Care Services II, Inc.		554	554	23
24	V	32 Interest		Forum Extended Care Services II, Inc.		115	115	24
25	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		7	7	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		\$ 17,223			\$ 23,427	\$ * 6,204	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	10a	Therapy	\$ 779,616	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 819,807	\$ 40,191	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			\$ 779,616			\$ 819,807	\$ * 40,191	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6	Repairs and Maintenance	\$ 33,587	Alden Bennett Construction Company, Inc.	0.00%	\$ 33,395	\$	(192)	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			\$ 33,587			\$ 33,395	\$ *	(192)	39

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

STATE OF ILLINIOS

Facility Name & ID Number Alden Village North

Provider No. 0049122

Report Period Beginning:

1/3/08

Ending: 12/31/08

RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
Name	City	Name	City	Type of Business
Heather Health Care Center, Inc.	Harvey	The Forum Professional Center, LP	Chicago	Home Office rental
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 Village North # 0049122 Report Period Beginning: 1/3/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President	CEO	100.00	175,063	1.096	0.03	Salary	\$ 4,937	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	65,362	1.096	0.03	Salary	1,843	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,026	1.096	0.03	Salary	1,072	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	\$ 7,852		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 Village North

0049122

Report Period Beginning:

1/3/08

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	1,216,590	30	\$ 73,771	\$ 33,371	\$ 2,024	1
2	24	Trav & Seminar	Patient Days	1,216,590	30	85,812	33,371	2,354	2
3	25	Other Admin Travel	Patient Days	1,216,590	30	294,582	33,371	8,080	3
4	26	Insurance	Patient Days	1,216,590	30	4,828	33,371	132	4
5	20	Dues & Subscriptions	Patient Days	1,216,590	30	13,344	33,371	366	5
6	30	Depreciation	No of Providers/usage	30	30	98,652	1	2,842	6
7	31	Amortization	Patient Days	1,216,590	30	1,500	33,371	41	7
8	33	Real Estate Tax	Patient Days/ysage	1,216,590	30	125,958	33,371	3,028	8
9	35	Rent-Equip & Vehicle	Patient Days	1,216,590	30	923,032	33,371	25,319	9
10	32	Interest	Patient Days/usage	1,216,590	30	1,783,086	33,371	65,212	10
11	1	Dietary	Patient Days	1,216,590	30	139,689	139,689	3,832	11
12	3	Housekeeping	Patient Days	1,216,590	30	98,076	98,076	2,690	12
13	7	Employee Benefits -Gen'I Servs	Patient Days	1,216,590	30	132,325	33,371	3,630	13
14	10	Nurs & Med Records Salary	Patient Days	1,216,590	30	1,256,694	1,256,694	30,686	14
15	15	Employee Benefits -Health Care	Patient Days	1,216,590	30	188,531	33,371	5,171	15
16	17	Administrative Salary	Patient Days/usage	1,216,590	30	2,118,865	2,118,865	98,035	16
17	27	Employee Benefits - Admin	Patient Days	1,216,590	30	1,163,122	33,371	31,904	17
18	19	Professional fees	Patient Days	1,216,590	30	978,599	605,253	26,843	18
19	21	Gen'I & Admin	Patient Days	1,216,590	30	5,848,424	5,104,656	160,422	19
20	6	Repair & Maint.	Patient Days	1,216,590	30	831,505	644,276	22,808	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 16,160,395	\$ 9,967,509	\$ 495,419	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Gemino Term Loan		X	Mortgage	Interest Only U	1/3/08	\$ 3,500,000	\$ 3,500,000	12/1/2012	9.0000	\$ 317,676	1								
2	Rel Party AMS-Fin Fee Amort										41	2								
3	Amortization of Fin Fees										14,495	3								
4												4								
5	Insurance Reclass (Interest)		X	Malpractice Insurance							2,895	5								
Working Capital																				
6	Gemino Revolver		X	Working Captial		1/3/08	2,000,000	1,559,365	12/1/2012	7.7500	132,920	6								
7	Related Party-AMS		X	Working Captial							65,212	7								
8	Related Party-FECII		X	Working Captial							115	8								
9	TOTAL Facility Related						\$ 5,500,000	\$ 5,059,365			\$ 533,354	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$		14							
15	TOTALS (line 9+line14)						\$ 5,500,000	\$ 5,059,365			\$ 533,354	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, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Village North COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049122

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(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 Serv</u>	\$ <u>295,853.00</u>	\$ <u>3,028.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care II</u>	\$ <u>28,917.00</u>	\$ <u>7.00</u>
3. <u>11-29-307-019-0000</u>	<u>7404 N. Sheridan Rd-Nursing Facility</u>	\$ <u>23,138.00</u>	\$ <u>23,138.00</u>
4. <u>11-29-307-020-0000</u>	<u>7402 N. Sheridan Rd-Nursing Facility</u>	\$ <u>22,402.00</u>	\$ <u>22,402.00</u>
5. <u>11-29-307-022-0000</u>	<u>7464 N. Sheridan Rd-Nursing Facility</u>	\$ <u>55,652.00</u>	\$ <u>55,652.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>425,962.00</u>	\$ <u>104,227.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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 Village North

0049122 Report Period Beginning:

1/3/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,708 B. General Construction Type: Exterior Load Bearing CMU, B Frame Steel Stud Number of Stories 3 + Basement

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>33,315</u>	<u>2008</u>	<u>\$ 358,296</u>	1
2					2
3	TOTALS	33,315		\$ 358,296	3

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning:

1/3/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2008	1968	\$ 2,984,341	\$ 76,522	39	\$ 76,522	\$	\$ 76,522	4
5											5
6											6
7											7
8	Related Party-Forum			1978	14,056		25			14,056	8
	Improvement Type**										
9	ABC-Doors			2008	5,996	550	10	550		550	9
10	ABC-Doors			2008	3,091	258	10	258		258	10
11	ABC-Cable lines			2008	4,230	353	10	353		353	11
12	ABC-Remodel - plumbing			2008	4,635	541	5	541		541	12
13	ABC-Door entry system			2008	2,850	95	10	95		95	13
14	ABC-Hvac- major repair to system			2008	4,583	917	5	917		917	14
15	Capps-Drains - major repairs			2008	3,875	646	5	646		646	15
16	Renovate-gen'l labor AMS			2008	10,664	1,422	5	1,422		1,422	16
17	Renovate-gen'l labor AMS			2008	11,352	1,324	5	1,324		1,324	17
18	Capps-Repipe shower lines			2008	4,585	306	5	306		306	18
19	ABCPlumbing - major repair			2008	4,885	81	5	81		81	19
20	Adj for ABC Related Party Profit			2008	(173)	(16)		(16)		(16)	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning:

1/3/08

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		\$ 3,058,970	\$ 82,997		\$ 82,997	\$	\$ 97,053	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 Improvement	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 Renovation	2003	1,583	157	10	157		950	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	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 base	1980	69		23			69	18
19	Leasehold Improvement-Add-on Improvement, lighting base	2001	119		5			119	19
20	Leasehold Improvements-fire extinguishers	2007	22	4	5	4		6	20
21	Leasehold Improvements-paving/glasswork/hvac/carpet	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 improv	1999	9,295	232	30	232		2,372	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,135,963	\$ 85,653		\$ 85,653	\$	\$ 162,565	34

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

Facility Name & ID Number Alden Village North # 0049122 Report Period Beginning: 1/3/08 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	\$ 14,198	\$ 1,376	\$ 1,376	\$	various	\$ 11,370	71
72	Current Year Purchases	445,691	77,556	77,556		various	77,556	72
73	Fully Depreciated Assets	60,758	69	69		various	60,758	73
74								74
75	TOTALS	\$ 520,647	\$ 79,001	\$ 79,001	\$		\$ 149,684	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				3	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)	\$ 4,019,469	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 164,654	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,654	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)	\$ 316,812	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 eliminated.

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning 1/2/08

Ending 1/2/18

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2009</u>	\$ <u>424,098</u>
13.	<u>12/31/2010</u>	\$ <u>424,098</u>
14.	<u>12/31/2011</u>	\$ <u>424,098</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,282 Description: Copy Machine Lease (GL 6861) & Other Office Equipment (GL6859)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Related Party-AMS</u>	<u>Various</u>	\$ <u>#####</u>	\$ <u>14,545</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>14,545</u>	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled nurses on site.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

Facility Name & ID Number Alden Village North# 0049122

Report Period Beginning:

1/3/08

Ending:

12/31/08

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				8,671		8,671	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		55,417			9,443		64,860	12
13	Other (specify):	See Pg 16A					145,943		145,943	13
14	TOTAL			\$ 55,417		\$	\$ 164,057		\$ 219,474	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.	Col. No.
1. OT	39-3	To Col 5	43,782
2. ST	39-3	To Col 5	59,225
3.			
4. PT	39-3	To Col 5	127,973
5.			
6.			
7.			
8.			
Less: OT, ST, & PT costs - reclassified to 10A for DD facilities			(230,980)
Total Lines 1,2 & 4			0.00
Pharmacy Supplies per GL			5,964
Manual Input from Related Party- Forum Drugs			2,707
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	8,671
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	55,417
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	9,443
Total Exceptional Care (Line 12, Col 8)			64,860
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	-
Other			732,245
Less: Respiratory Therapy Costs reclassified to line 10A			(548,809)
Manual Input: Related Party - Prism			(37,141)
Manual Input: Related Party FECII - I.V.			-
Manual Input: Related Party FECII - Wound Care			(352)
Oxygen, from reclass worksheet			-
13. Col 6: Supplies Total		To Col 6	145,943
13. Total Line 13, Column 8			145,943
14. Total			219,474

Facility Name & ID Number Alden Village North# 0049122Report Period Beginning: 1/3/08

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 450,811	\$ 471,506	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (1,000))	2,019,614	2,019,614	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		3,038	6
7	Other Prepaid Expenses	27,816	27,816	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,498,241	\$ 2,521,974	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		358,296	13
14	Buildings, at Historical Cost		2,984,341	14
15	Leasehold Improvements, at Historical Cost	162,178	162,178	15
16	Equipment, at Historical Cost	126,605	476,605	16
17	Accumulated Depreciation (book methods)	(35,493)	(182,015)	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 (spe <u>Fin Fees (Net)</u>)	17,980	76,530	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 271,270	\$ 3,875,935	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,769,511	\$ 6,397,909	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 462,828	\$ 469,028	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	632	632	28
29	Short-Term Notes Payable	1,559,365	1,559,365	29
30	Accrued Salaries Payable	200,782	200,782	30
31	Accrued Taxes Payable (excluding real estate taxes)	51,809	51,809	31
32	Accrued Real Estate Taxes(Sch.IX-B)		104,200	32
33	Accrued Interest Payable	16,361	43,486	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	35,618	35,618	36
37	<u>Accrued Day Training Exps</u>	236,538	236,538	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,563,933	\$ 2,701,458	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Affiliates</u>	346,350	452,393	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 346,350	\$ 3,952,393	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,910,283	\$ 6,653,851	46
47	TOTAL EQUITY(page 18, line 24)	\$ (140,772)	\$ (255,942)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,769,511	\$ 6,397,909	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	Zero - Purchased Jan 2008		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(141,772)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,000	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)	\$ (140,772)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (140,772)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning: 1/3/08

Ending: 12/31/08

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,589,062	1
2	Discounts and Allowances for all Levels	(490)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,588,572	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(906)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (906)	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Donation & Misc Income (Breakdown on Pg 19A)	58,091	28
28a	Day Training Revenues	529,268	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 587,359	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,175,025	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,456,532	31
32	Health Care	2,796,843	32
33	General Administration	1,495,665	33
B. Capital Expense			
34	Ownership	592,926	34
C. Ancillary Expense			
35	Special Cost Centers	1,563,317	35
36	Provider Participation Fee	411,514	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,316,797	40
41	Income before Income Taxes (line 30 minus line 40)**	(141,772)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (141,772)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Facility Name & ID Number Alden Village North # 0049122 Report Period Beginning: 1/3/08 Ending: 12/31/08

Details of Page 19, Line 28

Misc Income - Record Copies	Backed out on Page 5A	20
Misc Income - Jury Duty	Backed out on Page 5A	34
Misc Income - Food Rebate	Backed out on Page 5A	238
Misc Income - Wage Service Fees	Backed out on Page 5A	166
Misc Income - Donation to the home by expired resident		57633
		<u>58091</u>

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning: 1/3/08

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	1,717	1,955	\$ 71,406	\$ 36.52	1
2	Assistant Director of Nursing	406	483	16,486	34.13	2
3	Registered Nurses	23,007	24,504	749,975	30.61	3
4	Licensed Practical Nurses	11,094	11,469	263,497	22.97	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	1,632	1,688	55,417	32.83	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,064	2,080	36,856	17.72	9
10	Activity Assistants	104	104	887	8.53	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,004	2,172	56,821	26.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,755	17,251	187,064	10.84	15
16	Dishwashers					16
17	Maintenance Workers	2,106	2,226	43,614	19.59	17
18	Housekeepers	11,992	13,144	134,830	10.26	18
19	Laundry	11,314	12,197	118,977	9.75	19
20	Administrator	1,680	1,788	59,010	33.00	20
21	Assistant Administrator					21
22	Other Administrative	3,884	3,924	72,738	18.54	22
23	Office Manager	1,744	1,744	34,039	19.52	23
24	Clerical	6,108	6,500	81,511	12.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,428	5,595	86,138	15.40	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	94,740	99,254	1,115,094	11.23	30
31	Medical Records					31
32	Other Health Care Unit Director	534	558	6,444	11.55	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	197,313	208,636	\$ 3,190,804 *	\$ 15.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fee	\$ 10,800	1-3	35
36	Medical Director	Monthly Fee	60,100	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fee	1,874	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	Billed on a per re	178,399	11-3	44
45	Social Service Consultant	Monthly Fee	1,056	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 252,229		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 Village North

Report Period Beginning: 1/3/08 Ending:

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting	2008	87,992	3			17,851	29,331	29,331	11,479	0	0
3												
4												
5												
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7												
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9												
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12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 87,992		\$	\$	\$ 17,851	\$ 29,331	\$ 29,331	\$ 11,479	\$	\$

Facility Name & ID Number Alden Village North

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. \$3,560
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,194 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. \$ 411,514
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 24,827 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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.