

Facility Name & ID Number Alden of Old Town East

0042069 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 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,039	352		5,391
14	TOTALS	5,039	352		5,391

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.06%

D. How many bed-hold days during this year were paid by the Department? 317 (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 07/06/98

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Alden of Old Town East # 0042069 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				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	55,257	3,787		59,044	85	59,129	619	59,748		1
2	Food Purchase		48,735		48,735	(3,883)	44,852	(6,112)	38,740		2
3	Housekeeping	12,562	7,739		20,301	1,469	21,770	435	22,205		3
4	Laundry		1,386		1,386		1,386		1,386		4
5	Heat and Other Utilities			17,696	17,696		17,696	96	17,792		5
6	Maintenance	2,947		49,635	52,582		52,582	4,161	56,743		6
7	Other (specify):* Related Party							631	631		7
8	TOTAL General Services	70,766	61,647	67,331	199,744	(2,329)	197,415	(170)	197,245		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	407,786	20,097	2,181	430,064	1,384	431,448	5,262	436,710		10
10a	Therapy					4,917	4,917	(3,625)	1,292		10a
11	Activities		2,682	23,530	26,212		26,212		26,212		11
12	Social Services	47,513			47,513		47,513		47,513		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Benef.							835	835		15
16	TOTAL Health Care and Programs	455,299	22,779	28,711	506,789	6,301	513,090	2,472	515,562		16
	C. General Administration										
17	Administrative	14,452			14,452		14,452	20,957	35,409		17
18	Directors Fees										18
19	Professional Services			87,464	87,464	(52)	87,412	(76,344)	11,068		19
20	Dues, Fees, Subscriptions & Promotions			7,935	7,935		7,935	(5,365)	2,570		20
21	Clerical & General Office Expenses	8,319	4,286	11,266	23,871	52	23,923	26,911	50,834		21
22	Employee Benefits & Payroll Taxes			74,033	74,033	945	74,978	(24)	74,954		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,304	1,304		1,304	271	1,575		24
25	Other Admin. Staff Transportation			3,760	3,760		3,760	1,305	5,065		25
26	Insurance-Prop.Liab.Malpractice			17,740	17,740	(139)	17,601	1,539	19,140		26
27	Other (specify):* Bad Debt & Related Party Benef.			1,585	1,585		1,585	3,682	5,267		27
28	TOTAL General Administration	22,771	4,286	205,087	232,144	806	232,950	(27,068)	205,882		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	548,836	88,712	301,129	938,677	4,778	943,455	(24,766)	918,689		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,673	5,673		5,673	32,553	38,226			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,357	22,357	139	22,496	56,952	79,448			32
33	Real Estate Taxes							13,658	13,658			33
34	Rent-Facility & Grounds			93,178	93,178		93,178	(93,178)				34
35	Rent-Equipment & Vehicles			3,828	3,828		3,828	4,090	7,918			35
36	Other (specify):* M.I.P.							6,427	6,427			36
37	TOTAL Ownership			125,036	125,036	139	125,175	20,502	145,677			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,863	4,917	7,780	(4,917)	2,863	628	3,491			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,036	64,036		64,036		64,036			42
43	Other (specify):* day training			262,578	262,578		262,578		262,578			43
44	TOTAL Special Cost Centers		2,863	331,531	334,394	(4,917)	329,477	628	330,105			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	548,836	91,575	757,696	1,398,107		1,398,107	(3,636)	1,394,471			45

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

Alden of Old Town East
 Reclassifications on Pgs 3 & 4 - Column 5
 Report Period Beginning: 1/1/2008
 Report Period Ending: 12/31/2008

IDPH Facility ID Number: #0042069

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(3,883.00)	Employee Meals
	22	3,883.00	Employee Meals
22		(2,938.00)	Uniforms
	10	1,384.00	Uniforms
	1	85.00	Uniforms
	3	1,469.00	Uniforms
26		(139.00)	Interest - old policy/curr yr portion
	32	139.00	Interest - old policy/curr yr portion
 <u>Others, if any:</u>			
19		(52.00)	Medi-Com Software Services
	21	52.00	Medi-Com Software Services
 <u>Applicable only if provider had a real estate tax refund relating to the 1999 or earlier tax year:</u>			
 <u>DD Providers Only:</u>			
39		(4,917.00)	PT, OT, & ST CPT Therapy Costs
	10A	4,917.00	PT, OT, & ST CPT Therapy Costs
Net		<hr/>	-

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	(161)	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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,707)	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	(1,585)	27		24
25	Fund Raising, Advertising and Promotional	(3,409)	20		25
	Income Taxes and Illinois Personal				
26	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)	\$ (6,862)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	7,140	Various	34
35	Other- Attach Schedule	(3,914)	pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,226		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,636)		37

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

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

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

Alden of Old Town East

ID# 0042069

Report Period Beginning: 1/1/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Late Fee on Utilities	(231)	5	2
3	Intercompany Interest	(7,448)	32	3
4	Misc Income (Wage Service Fee)	(24)	22	4
5	Misc Income (Gait Belts)	(100)	21	5
6	Back out 32.3% of PAC fees from IHCA bills	(285)	20	6
7	Vendor Settlements (Relational Tech Solutions)	(400)	21	7
8	Vendor Settlements (Relational Tech Solutions)	400	6	8
9	Deming Training Cost	(109)	24	9
10	Eliminate PAC fee	(140)	20	10
11	Back out interest adjustment related to prior year	(187)	32	11
12	Expense Related Party Items < \$2,500	774	6	12
13	Back out Rent Adj.	(259)	34	13
14	Elim Deprec on Pg 13 < \$2,500	(851)	30	14
15	Expense Pg 13 items < \$2,500	5,074	6	15
16	Adj. Depreciation Expense	(128)	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	(3,914)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town East

0042069

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	619	0	0	0	0	0	0	0	0	619	1
2	Food Purchase	(161)	0	0	(5,951)	0	0	0	0	0	0	0	(6,112)	2
3	Housekeeping	0	0	435	0	0	0	0	0	0	0	0	435	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(231)	0	327	0	0	0	0	0	0	0	0	96	5
6	Maintenance	6,248	0	(1,972)	0	0	0	(115)	0	0	0	0	4,161	6
7	Other (specify):*	0	0	586	45	0	0	0	0	0	0	0	631	7
8	TOTAL General Services	5,856	0	(5)	(5,906)	0	0	(115)	0	0	0	0	(170)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,957	176	129	0	0	0	0	0	0	5,262	10
10a	Therapy	0	0	0	0	0	(3,625)	0	0	0	0	0	(3,625)	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	835	0	0	0	0	0	0	0	0	835	15
16	TOTAL Health Care and Programs	0	0	5,792	176	129	(3,625)	0	0	0	0	0	2,472	16
	C. General Administration													
17	Administrative	0	0	20,957	0	0	0	0	0	0	0	0	20,957	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,849	(78,193)	0	0	0	0	0	0	0	0	(76,344)	19
20	Fees, Subscriptions & Promotions	(5,541)	117	59	0	0	0	0	0	0	0	0	(5,365)	20
21	Clerical & General Office Expenses	(500)	0	25,917	1,215	279	0	0	0	0	0	0	26,911	21
22	Employee Benefits & Payroll Taxes	(24)	0	0	0	0	0	0	0	0	0	0	(24)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(109)	0	380	0	0	0	0	0	0	0	0	271	24
25	Other Admin. Staff Transportation	0	0	1,305	0	0	0	0	0	0	0	0	1,305	25
26	Insurance-Prop.Liab.Malpractice	0	1,518	21	0	0	0	0	0	0	0	0	1,539	26
27	Other (specify):*	(1,585)	0	5,154	129	(16)	0	0	0	0	0	0	3,682	27
28	TOTAL General Administration	(7,759)	3,484	(24,400)	1,344	263	0	0	0	0	0	0	(27,068)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,903)	3,484	(18,613)	(4,386)	392	(3,625)	(115)	0	0	0	0	(24,766)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town East

0042069

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	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	(979)	29,342	2,842	0	1,348	0	0	0	0	0	0	32,553	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,635)	54,021	10,543	0	23	0	0	0	0	0	0	56,952	32
33	Real Estate Taxes	0	13,168	489	0	1	0	0	0	0	0	0	13,658	33
34	Rent-Facility & Grounds	(259)	(92,919)	0	0	0	0	0	0	0	0	0	(93,178)	34
35	Rent-Equipment & Vehicles	0	0	4,090	0	0	0	0	0	0	0	0	4,090	35
36	Other (specify):*	0	6,427	0	0	0	0	0	0	0	0	0	6,427	36
37	TOTAL Ownership	(8,873)	10,039	17,964	0	1,372	0	0	0	0	0	0	20,502	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	(319)	947	0	0	0	0	0	0	628	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	(319)	947	0	0	0	0	0	0	628	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,776)	13,523	(649)	(4,705)	2,711	(3,625)	(115)	0	0	0	0	(3,636)	45

Facility Name & ID Number

Alden of Old Town East

0042069

Report Period Beginning:

1/1/08

Ending:

12/31/08

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 Rental Income	\$ 92,919	Alden of Bloomingdale Limited Partnership		\$	\$ (92,919)	1
2	V	32 Interest Income	14,535	Alden of Bloomingdale Limited Partnership			(14,535)	2
3	V	32 Interest Income - RR	235	Alden of Bloomingdale Limited Partnership			(235)	3
4	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		1,833	1,833	4
5	V	19 Bank Charges		Alden of Bloomingdale Limited Partnership		16	16	5
6	V	20 Dues & Subscriptions		Alden of Bloomingdale Limited Partnership		117	117	6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		13,168	13,168	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,518	1,518	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		6,427	6,427	9
10	V	32 Interest - Other		Alden of Bloomingdale Limited Partnership		46,215	46,215	10
11	V	32 Interest - IOD		Alden of Bloomingdale Limited Partnership		21,974	21,974	11
12	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		29,342	29,342	12
13	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		602	602	13
14	Total		\$ 107,689			\$ 121,212	\$ * 13,523	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%	\$ 327	\$	327	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		380		380	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,305		1,305	17
18	V	26 Insurance		Alden Management Services, Inc.		21		21	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		59		59	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,842		2,842	20
21	V	32 Amortization		Alden Management Services, Inc.		7		7	21
22	V	33 Real Estate Taxes		Alden Management Services, Inc.		489		489	22
23	V	35 Rent-Equipment & Vehicles		Alden Management Services, Inc.		4,090		4,090	23
24	V	32 Interest		Alden Management Services, Inc.		10,536		10,536	24
25	V	1 Dietary		Alden Management Services, Inc.		619		619	25
26	V	3 Housekeeping Salary		Alden Management Services, Inc.		435		435	26
27	V	7 Employee Benefits - Gen'l Servs		Alden Management Services, Inc.		586		586	27
28	V	10 Nurs/Med Records Salary		Alden Management Services, Inc.		4,957		4,957	28
29	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		835		835	29
30	V	17 Administrative Salary		Alden Management Services, Inc.		20,957		20,957	30
31	V	27 Employee Benefits - Administrative		Alden Management Services, Inc.		5,154		5,154	31
32	V	19 Professional Fees	82,529	Alden Management Services, Inc.		4,336		(78,193)	32
33	V	21 General & Admin.		Alden Management Services, Inc.		25,917		25,917	33
34	V	6 Repair & Maintenance	5,657	Alden Management Services, Inc.		3,685		(1,972)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 88,186			\$ 87,537	\$ *	(649)	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	\$ 9,054	Prism Health Care Services, Inc.	0.00%	\$ 3,103	\$ (5,951)	15
16	V	10 Equipment Rental	360	Prism Health Care Services, Inc.		536	176	16
17	V	39 Ancillary Supplies	607	Prism Health Care Services, Inc.		288	(319)	17
18	V	21 Gen'l & Admin Salaries		Prism Health Care Services, Inc.		730	730	18
19	V	27 Employee Benefits		Prism Health Care Services, Inc.		129	129	19
20	V	7 Employee Benefits		Prism Health Care Services, Inc.		45	45	20
21	V	21 Gen'l & Admin Costs		Prism Health Care Services, Inc.		485	485	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		\$ 10,021			\$ 5,316	\$ * (4,705)	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	\$ 2,139	Forum Extended Care Services II, Inc.	0.00%	\$ 3,110	\$ 971	15
16	V	39 Wound Care	117	Forum Extended Care Services II, Inc.		93	(24)	16
17	V	10 House Stock	618	Forum Extended Care Services II, Inc.		583	(35)	17
18	V	10 Pharm. Consult.	384	Forum Extended Care Services II, Inc.		548	164	18
19	V	27 Employ. Vaccin.	179	Forum Extended Care Services II, Inc.		143	(36)	19
20	V	27 Employ. Benef: Gen'l & Admin		Forum Extended Care Services II, Inc.		20	20	20
21	V	21 Salary: Gen'l & Admin		Forum Extended Care Services II, Inc.		169	169	21
22	V	21 Gen'l & Admin		Forum Extended Care Services II, Inc.		110	110	22
23	V	32 Interest		Forum Extended Care Services II, Inc.		23	23	23
24	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		1	1	24
25	V	30 Depreciation		Forum Extended Care Services II, Inc.		1,348	1,348	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		\$ 3,437			\$ 6,148	\$ * 2,711	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	\$ 4,917	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,292	\$ (3,625)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
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		\$ 4,917			\$ 1,292	\$ * (3,625)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Repairs & Maintenance	\$ 20,063	Alden Bennett Construction Company, Inc.	0.00%	\$ 19,948	\$	(115)	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		\$ 20,063			\$ 19,948	\$ *	(115)	39

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

Facility Name & ID Number Alden of Old Town East

Provider No. 0042069

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 of Old Town East # 0042069 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	179,202	0.176	0.00	Salary	\$ 798	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	66,907	0.176	0.00	Salary	298	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,926	0.176	0.00	Salary	173	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	\$ 1,269		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 of Old Town East

0042069

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	\$	5,391	\$ 327	1	
2	24	Travel/Seminar	patient days*	30	85,812		5,391	380	2	
3	25	Other Admin Travel	patient days*	30	294,582		5,391	1,305	3	
4	26	Insurance	patient days*	30	4,828		5,391	21	4	
5	20	Dues/Subscriptions	patient days*	30	13,344		5,391	59	5	
6	30	Depreciation	no. of providers	30	98,652		1	2,842	6	
7	31	Amortization	patient days*	30	1,500		5,391	7	7	
8	33	Real Estate Tax	patient days*	30	125,958		5,391	489	8	
9	35	Rent-Equip/Vehicle	patient days*	30	923,032		5,391	4,090	9	
10	32	Interest	patient days*	30	1,783,086		5,391	10,536	10	
11	1	Dietary Salary	patient days*	30	139,689	139,689	5,391	619	11	
12	3	Housekeeping Salary	patient days*	30	98,076	98,076	5,391	435	12	
13	7	Employee Benef-Gen'l Servs	patient days*	30	132,325		5,391	586	13	
14	10	Nurs/Med Rec Salary	patient days*	30	1,256,694	1,256,694	5,391	4,957	14	
15	15	Employee Benef-Health Care	patient days*	30	188,531		5,391	835	15	
16	17	Administrative Salary	patient days*	30	2,118,865	2,118,865	5,391	20,957	16	
17	27	Employee Benef-Administrative	patient days*	30	1,163,122		5,391	5,154	17	
18	19	Professional Fees	patient days*	30	978,599	605,253	5,391	4,336	18	
19	21	Gen'l & Admin	patient days*	30	5,848,424	5,104,656	5,391	25,917	19	
20	6	Repair & Mainten.	patient days*	30	831,505	644,276	5,391	3,685	20	
21									21	
22		*The allocation is based on patient days, however, there may be some instances in which a home office cost could be directly associated with the provider.								22
23		In those rare cases, the cost would not be part of the overall allocation process but directly allocated to the appropriate provider.								23
24									24	
25	TOTALS				\$ 16,160,395	\$ 9,967,509		\$ 87,537	25	

Facility Name & ID Number

Alden of Old Town East

0042069

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Cambridge		X	Operating Loss Loan	\$2,122.33	6/02	\$ 339,716	\$ 320,252	09/2037	6.8600	\$ 21,974	1						
2	Cambridge		X	Mortgage	\$4,506.29	9/03	873,700	836,474	08/2043	5.5000	46,215	2						
3												3						
4	Amortization of Finance Fees		X	Financing							609	4						
5	Insurance Interest		X	Insurance							327	5						
Working Capital																		
6												6						
7	Related Party-AMS		X	Working Capital							10,536	7						
8	Related Party-FECH		X	Working Capital							23	8						
9	TOTAL Facility Related				\$6,628.62		\$ 1,213,416	\$ 1,156,726			\$ 79,684	9						
B. Non-Facility Related*																		
10	Interest - Repl Reserve	X									(235)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (235)	14						
15	TOTALS (line 9+line14)						\$ 1,213,416	\$ 1,156,726			\$ 79,448	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,427 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	13,365	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	12,486	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(879)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	14,047	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	13,168	7
			490	
Real Estate Tax History:		\$	13,658	

Plus: Related Party Taxes - See Pg 10A

Real Estate Tax Bill for Calendar Year:	2003	11,685	8
	2004	12,164	9
	2005	11,815	10
	2006	12,976	11
	2007	12,486	12

The current year accrual is based on an estimated 3% increase of the prior year tax.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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 of Old Town East COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0042069

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 Ser</u>	\$ <u>295,853.00</u>	\$ <u>489.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	\$ <u>28,917.00</u>	\$ <u>1.00</u>
3. <u>02-15-201-020</u>	<u>Nursing Facility</u>	\$ <u>12,485.52</u>	\$ <u>12,485.52</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>337,255.52</u>	\$ <u>12,975.52</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 of Old Town East

0042069

Report Period Beginning:

1/1/08

Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>14,400</u>	<u>1995</u>	<u>\$ 150,686</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	14,400		\$ 150,686	3

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	1997	1997	934,861	23,372	40	23,372		246,022
5									
6									
7									
8	Related Party-Forum		1978	14,056		25			14,056
	Improvement Type**								
9	TV Modules		1999	1,775		5			1,775
10	Sprinkler system		2001	2,345	235	10	235		1,799
11									
12	ABC Counter Tops		2003	8,091	809	10	809		4,652
13	ABC roof repair		2003	1,685	168	10	168		856
14									
15	Central States Automati(Sprinkler Repair)		2005	1,614	161	10	161		618
16	Alden Bennett Const(Door Installation)		2005	1,882	188	10	188		674
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 & ID Number Alden of Old Town East

0042069

Report Period Beginning:

1/1/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 966,309	\$ 24,933		\$ 24,933	\$	\$ 270,452	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, 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 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)		\$ 1,043,302	\$ 27,588		\$ 27,588	\$	\$ 335,964	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	\$ 121,606	\$ 9,558	\$ 9,558	\$		\$ 81,369	71
72	Current Year Purchases	7,080	614	614			614	72
73	Fully Depreciated Assets	73,922	316	316			73,922	73
74								74
75	TOTALS	\$ 202,608	\$ 10,488	\$ 10,488	\$		\$ 155,905	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	AMS-Bus/Travel Van	Chev/Lumina/00/Various	98-04	\$ 4,634	\$	\$	\$	3	\$ 4,634	76
77										77
78	Bills Auto & Truck	Major Capital Repair	2002	817	150	150		5	790	78
79	Related Party - AMS	Various	'98-'04	4,563				3	4,563	79
80	TOTALS			\$ 10,014	\$ 150	\$ 150	\$		\$ 9,987	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)	\$ 1,406,610	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,226	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 38,226	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)	\$ 501,856	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? YES NO

If NO, see instructions.

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

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: N/A *

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

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

16. Rental Amount for movable equipment: \$ 3,828 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	<u>Related Party - AMS</u>	<u>Various</u>	\$ <u>195.83</u>	\$ <u>2,350</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>195.83</u>	\$ <u>2,350</u>	21

10. Effective dates of current rental agreement:

Beginning 12/02/1996

Ending 11/30/2036

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

* 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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescripts				3,110		3,110	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					381		381	13
14	TOTAL			\$		\$	3,491		\$ 3,491	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	\$1,146.65
2. ST	39-3	To Col 5	1,266.23
3.			
4. PT	39-3	To Col 5	2,504.34
5.			
6.			
7.			
8. Less PT, OT, & ST costs reclassified to Ln 10A for "DD" type facilities			(4,917.22)
Pharmacy Supplies per GL			2,139.19
Manual Input from Related Party- Forum Drugs			971.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	3,110.19
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	0.00
Total Exceptional Care (Line 12, Col 8)			0.00
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Col 5	
Other			723.86
Manual Input: Related Party - Prism			(319.00)
Manual Input: Related Party FECII - Wound Care			(24.00)
Oxygen, from reclass worksheet			0.00
13. Col 6: Supplies Total		To Col 6	380.86
13. Total Line 13, Column 8			380.86
14. Total			3,491.05

Facility Name & ID Number Alden of Old Town East

0042069

Report Period Beginning: 1/1/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,000</u>)	294,216	294,216	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,097	6
7	Other Prepaid Expenses	1,202	1,202	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From 3rd Parties</u>	24,631	24,631	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 320,049	\$ 325,146	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	20,885	27,150	15
16	Equipment, at Historical Cost	70,200	152,340	16
17	Accumulated Depreciation (book methods)	(59,876)	(361,907)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		56,576	21
22	Other Long-Term Assets (specify: <u>Refinance Fees</u>)		18,722	22
23	Other(specify): <u>Due From Affiliates</u>	682,461	903,616	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 713,670	\$ 1,874,847	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,033,719	\$ 2,199,993	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 208,390	\$ 207,265	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,667	4,667	28
29	Short-Term Notes Payable		11,985	29
30	Accrued Salaries Payable	35,336	35,336	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,754	6,754	31
32	Accrued Real Estate Taxes(Sch.IX-B)		14,033	32
33	Accrued Interest Payable	1,205	5,657	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>accr ins, exps, idpa, sales tax, etc.</u>	3,043	3,043	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 259,395	\$ 288,740	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		316,543	39
40	Mortgage Payable		828,199	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to affiliates</u>			43
44	<u>Shareholder Loans/Others</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,144,741	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 259,395	\$ 1,433,481	46
47	TOTAL EQUITY(page 18, line 24)	\$ 774,324	\$ 766,512	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,033,719	\$ 2,199,993	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 551,105	1
2	Restatements (describe):		2
3	External audit adjustment made after 2007 cost report		3
4	was submitted. These have no effect on prior year's report:	184,823	4
5	Fines, Penalties, & Unallowable Costs		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 735,928	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	38,396	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)	\$ 38,396	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)	\$ 774,324	24 *

* This must agree with page 17, line 47.

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	\$ 1,173,648	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,173,648	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	262,855	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 262,855	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,436,503	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	199,744	31
32	Health Care	506,789	32
33	General Administration	232,144	33
	B. Capital Expense		
34	Ownership	125,036	34
	C. Ancillary Expense		
35	Special Cost Centers	270,358	35
36	Provider Participation Fee	64,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,398,107	40
41	Income before Income Taxes (line 30 minus line 40)**	38,396	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 38,396	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 of Old Town East

0042069

Report Period Beginning:

1/1/08

Ending:

12/31/08

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Late Fee	\$ (30)
Misc Income - Vending Machine Receipt	100
Misc Income - Wage Service Fee	24
Gain on Sale of Assets	183
Day Training	<u>262,578</u>
Line 28 Total:	<u>\$ 262,855</u>

Facility Name & ID Number Alden of Old Town East

0042069

Report Period Beginning:

1/1/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	2,942	2,942	92,268	31.36	3
4	Licensed Practical Nurses	2,198	2,198	60,384	27.47	4
5	CNAs & Orderlies	15	15	142	9.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	130	130	2,491	19.16	13
14	Head Cook	4,160	4,160	50,024	12.03	14
15	Cook Helpers/Assistants	259	259	2,742	10.59	15
16	Dishwashers					16
17	Maintenance Workers	130	130	2,947	22.67	17
18	Housekeepers	1,317	1,317	12,562	9.54	18
19	Laundry					19
20	Administrator	520	520	14,452	27.79	20
21	Assistant Administrator					21
22	Other Administrative	228	228	8,319	36.49	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,651	2,651	47,513	17.92	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,346	22,717	254,992	11.22	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	35,896	37,267	\$ 548,836 *	\$ 14.73	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	250/Month	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32/Month	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	421	22,738	11-3	44
45	Social Service Consultant	15	792	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	436	\$ 26,914		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	2	42	10-3	52
53	TOTAL (lines 50 - 52)	2	\$ 42		53

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1	Painting	3/06	\$ 2,675	3	\$	\$ 743	\$ 892	\$ 892	\$ 148	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 2,675		\$	\$ 743	\$ 892	\$ 892	\$ 148	\$	\$	\$	\$							

Facility Name & ID Number Alden of Old Town East

0042069

Report Period Beginning:

1/1/08

Ending:

12/31/08

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. II. Health Care Assn. \$597
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,121 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. \$ 64,036
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. \$ 3,883 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. \$ _____
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? 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees