

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

0040709 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	3,498	797	3,621	7,916	8
9	SNF/PED					9
10	ICF	18,848	2,315	139	21,302	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,346	3,112	3,760	29,218	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.38%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 33 and days of care provided 2,548

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care # 0040709 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	221,976	13,119	10,800	245,895	1,150	247,045	2,270	249,315		1
2	Food Purchase		201,709		201,709	(28,992)	172,717	(31,249)	141,468		2
3	Housekeeping	101,160	31,035		132,195	363	132,558	2,594	135,152		3
4	Laundry	63,728	9,955		73,683	438	74,121		74,121		4
5	Heat and Other Utilities			110,160	110,160		110,160	418	110,578		5
6	Maintenance	63,708		97,177	160,885	1,408	162,293	24,184	186,477		6
7	Other (specify):* Related Party Benefits							4,141	4,141		7
8	TOTAL General Services	450,572	255,818	218,137	924,527	(25,633)	898,894	2,358	901,252		8
	B. Health Care and Programs										
9	Medical Director			27,000	27,000		27,000		27,000		9
10	Nursing and Medical Records	1,357,483	142,341	2,304	1,502,128	(25,162)	1,476,966	29,377	1,506,343		10
10a	Therapy	56,784			56,784		56,784		56,784		10a
11	Activities	46,465	1,306	3,304	51,075	97	51,172		51,172		11
12	Social Services	40,311			40,311		40,311		40,311		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Benefits							4,574	4,574		15
16	TOTAL Health Care and Programs	1,501,043	143,647	32,608	1,677,298	(25,065)	1,652,233	33,951	1,686,184		16
	C. General Administration										
17	Administrative	84,253			84,253		84,253	56,263	140,516		17
18	Directors Fees										18
19	Professional Services			391,692	391,692	(13,835)	377,857	(337,687)	40,170		19
20	Dues, Fees, Subscriptions & Promotions			62,635	62,635		62,635	(56,113)	6,522		20
21	Clerical & General Office Expenses	103,653	15,884	35,559	155,096	(910)	154,186	149,265	303,451		21
22	Employee Benefits & Payroll Taxes			325,375	325,375	22,632	348,007	(4,754)	343,253		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,285	5,285		5,285	1,574	6,859		24
25	Other Admin. Staff Transportation			194	194		194	6,779	6,973		25
26	Insurance-Prop.Liab.Malpractice			108,775	108,775		108,775	95	108,870		26
27	Other (specify):* Related Party Benefits			95,384	95,384		95,384	(61,907)	33,477		27
28	TOTAL General Administration	187,906	15,884	1,024,899	1,228,689	7,887	1,236,576	(246,485)	990,091		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,139,521	415,349	1,275,644	3,830,514	(42,811)	3,787,703	(210,176)	3,577,527		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 Lincoln Rehabilitation & Health Care Center #0040709 Report Period Beginning: 1/1/09 Ending: 12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			41,859	41,859		41,859	(3,764)	38,095			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,444	39,444		39,444	(8,951)	30,493			32
33	Real Estate Taxes			113,770	113,770		113,770	3,336	117,106			33
34	Rent-Facility & Grounds			502,366	502,366		502,366		502,366			34
35	Rent-Equipment & Vehicles			8,415	8,415		8,415	22,647	31,062			35
36	Other (specify):*											36
37	TOTAL Ownership			705,854	705,854		705,854	13,268	719,122			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		279,559	285,799	565,358	42,811	608,169	(23,061)	585,108			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		279,559	338,359	617,918	42,811	660,729	(23,061)	637,668			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,139,521	694,908	2,319,857	5,154,286		5,154,286	(219,969)	4,934,317			45

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

Reclassifications on Pgs 3 & 4 - Column 5

Report Period Beginning: 1/1/2009

Report Period Ending: 12/31/2009

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(28,992.00)	Employee Meals
	22	28,992.00	Employee Meals
22		(6,360.00)	Uniforms
	1	1,150.00	Uniforms
	3	363.00	Uniforms
	4	438.00	Uniforms
	6	152.00	Uniforms
	10	3,814.00	Uniforms
	11	97.00	Uniforms
	21	346.00	Uniforms
10		(42,811.00)	Oxygen - to appropriate cost center
	39	42,811.00	Oxygen - to appropriate cost center
21		(1,256.00)	Vendor Settlements
	6	1,256.00	Vendor Settlements (may effect more than one line)
19		(13,835.00)	reclass Clinical Coordinators (Pathway) to Line 10
	10	13,835.00	reclass Clinical Coordinators (Pathway) to Line 10

Net _____
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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	(8,309)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(967)	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	(28)	21		17
18	Fines and Penalties	(25)	32		18
19	Entertainment	(1,545)	20		19
20	Contributions	(5,853)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,395)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,384)	27		24
25	Fund Raising, Advertising and Promotional	(12,935)	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)	\$ (130,441)		\$	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)	(18,689)	various	34
35	Other- Attach Schedule	(70,839)	pg5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (89,528)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (219,969)		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					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					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 Lincoln Rehabilitation & Health Care Center

ID# 0040709

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees on Utilities	\$ (1,162)	5	1
2	Intercompany Interest	(39,419)	32	2
3	Misc Income (general)	(300)	6	3
4	Misc Income - food rebate	(732)	2	4
5	Misc Income (polling site)	(275)	6	5
6	Misc Income (medical records)	(234)	10	6
7	back out Marketing Manager Salaries	(31,262)	21	7
8	back out Employee benefit - Mktg Manager Salaries	(4,754)	22	8
9	back out IHCA PAC Fees	(1,590)	20	9
10	Deming Leadership Training adjustment	(620)	24	10
11	add back prior years Real Estate Tax Refund	170	33	11
12	reduce depreciation exp pg 13<\$2,500	(5,731)	30	12
13	reduce depreciation exp pg 12<\$2,500	(2,261)	30	13
14	expense capital adj <\$2,500 on pg 13	11,903	6	14
15	expense capital adj <\$2,500 on pg 12	4,645	6	15
16	depreciation adjustment	3	30	16
17				17
18	adj for ABC related party profit - pg 12	(4)	30	18
19	adj for ABC related party profit - pg 12	(2)	30	19
20				20
21	expense capital items<\$2,500 pg 13 Rel Party	786	6	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	(70,839)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 1,580	\$ 1,580 15
16	V	24 Travel and Seminar		Alden Management Services, Inc.		2,194	2,194 16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		6,779	6,779 17
18	V	26 Insurance		Alden Management Services, Inc.		95	95 18
19	V	20 Dues and Subscription	34,512	Alden Management Services, Inc.		322	(34,190) 19
20	V	30 Depreciation		Alden Management Services, Inc.		2,864	2,864 20
21	V	33 Real estate taxes		Alden Management Services, Inc.		3,003	3,003 21
22	V	35 Rent - Equipment & Vehic		Alden Management Services, Inc.		22,647	22,647 22
23	V	32 Interest		Alden Management Services, Inc.		38,013	38,013 23
24	V	1 Dietary		Alden Management Services, Inc.		3,512	3,512 24
25	V	3 Housekeeping		Alden Management Services, Inc.		2,594	2,594 25
26	V	7 Employee Benefit - Gen Services		Alden Management Services, Inc.		3,417	3,417 26
27	V	10 Nurse & Medical Records Salary		Alden Management Services, Inc.		27,519	27,519 27
28	V	15 Employee Benefit - Health Care		Alden Management Services, Inc.		4,574	4,574 28
29	V	17 Administrative Salary		Alden Management Services, Inc.		56,263	56,263 29
30	V	27 Employee Benefit - Admin		Alden Management Services, Inc.		30,475	30,475 30
31	V	19 Professional Fee	356,660	Alden Management Services, Inc.		24,368	(332,292) 31
32	V	21 General and Administrative		Alden Management Services, Inc.		147,502	147,502 32
33	V	6 Repairs and Maintenance	13,517	Alden Management Services, Inc.		21,104	7,587 33
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 404,689			\$ 398,825	\$ * (5,864) 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	1 Diet Consultant	\$ 10,800	Prism Health Care Services, Inc.	0.00%	\$ 2,711	\$ (8,089)	15
16	V	1 Diet Salary		Prism Health Care Services, Inc.		6,847	6,847	16
17	V	2 Tube Feeding	39,572	Prism Health Care Services, Inc.		10,022	(29,550)	17
18	V	10 Equipment Rental	6,660	Prism Health Care Services, Inc.		7,855	1,195	18
19	V	39 Ancillary Supplies	72,915	Prism Health Care Services, Inc.		40,035	(32,880)	19
20	V	21 Salary - G & A		Prism Health Care Services, Inc.		10,898	10,898	20
21	V	27 Employee Benefit		Prism Health Care Services, Inc.		2,082	2,082	21
22	V	7 Employee Benefit		Prism Health Care Services, Inc.		724	724	22
23	V	21 General and Administrative		Prism Health Care Services, Inc.		5,898	5,898	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		\$ 129,947			\$ 87,072	\$ * (42,875)	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 <u>Drugs</u>	\$ 123,589	<u>Forum Extended Care Services II, Inc.</u>	0.00%	\$ 169,449	\$ 45,860
16	V	39 <u>IV</u>	68,470	<u>Forum Extended Care Services II, Inc.</u>		9,033	(59,437)
17	V	39 <u>Wound Care</u>	8,838	<u>Forum Extended Care Services II, Inc.</u>		6,969	(1,869)
18	V	10 <u>House Stock</u>	4,521	<u>Forum Extended Care Services II, Inc.</u>		4,101	(420)
19	V	10 <u>Pharmacy Consultant</u>	2,304	<u>Forum Extended Care Services II, Inc.</u>		3,621	1,317
20	V	27 <u>Employee Vaccination</u>	1,555	<u>Forum Extended Care Services II, Inc.</u>		1,228	(327)
21	V	27 <u>Employee Benefit: G & A</u>		<u>Forum Extended Care Services II, Inc.</u>		1,247	1,247
22	V	21 <u>Salary: G & A</u>		<u>Forum Extended Care Services II, Inc.</u>		10,366	10,366
23	V	21 <u>General and Administrative</u>		<u>Forum Extended Care Services II, Inc.</u>		5,891	5,891
24	V	32 <u>Interest</u>		<u>Forum Extended Care Services II, Inc.</u>		789	789
25	V	33 <u>Real Estate Tax</u>		<u>Forum Extended Care Services II, Inc.</u>		163	163
26	V	30 <u>Depreciation</u>		<u>Forum Extended Care Services II, Inc.</u>		1,367	1,367
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		\$ 209,277			\$ 214,224	\$ * 4,947

* 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 Therapy	\$ 279,092	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 304,357	\$ 25,265	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		\$ 279,092			\$ 304,357	\$ *	25,265	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	\$ 12,215	Alden Bennett Construction Company, Inc.	0.00%	\$ 12,053	\$ (162)
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		\$ 12,215			\$ 12,053	\$ * (162)

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

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center Provider No. 0040709

Report Period Beginning:

1/1/09

Ending: 12/31/09

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			
Alden Estates of Skokie, Inc.	Skokie			

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care # 0040709 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	180,576	0.956	2.39	Salary	\$ 4,424	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	66,999	0.956	2.39	Salary	1,641	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,575	0.956	2.39	Salary	945	6-7	3
4											4
5											5
6											6
7	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	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.										8
9	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.										9
10											10
11											11
12											12
13								TOTAL	\$ 7,010		13

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

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

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center # 0040709 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	31	\$ 66,061	\$	29,235	\$ 1,580	1
2	24	Travel/Seminar	Patient days	31	91,753		29,235	2,194	2
3	25	Other Admin Travel	Patient days	31	283,487		29,235	6,779	3
4	26	Insurance	Patient days	31	3,990		29,235	95	4
5	20	Dues/Subscriptions	Patient days	31	13,454		29,235	322	5
6	30	Depreciation	No. of Providers	31	102,169		1	2,864	6
7	33	Real Estate Tax	Patient days	31	139,876		29,235	3,003	7
8	35	Rent-Equip & Vehicles	Patient days	31	947,116		29,235	22,647	8
9	32	Interest	Patient days	31	1,339,694		29,235	38,013	9
10	1	Diet. Salary	Patient days	31	146,892	146,892	29,235	3,512	10
11	3	Housekeeping Salary	Patient days	31	108,487	108,487	29,235	2,594	11
12	7	Employee Benefits-Gen'l Servs	Patient days	31	142,881		29,235	3,417	12
13	10	Nurs & Med Record Salary	Patient days	31	1,259,741	1,259,741	29,235	27,519	13
14	15	Employee Benefits-Health Care	Patient days	31	191,270		29,235	4,574	14
15	17	Administrative Salary	Patient days	31	2,477,865	2,477,865	29,235	56,263	15
16	27	Employee Benefits-Administr.	Patient days	31	1,274,479		29,235	30,475	16
17	19	Professional Fees	Patient days	31	1,019,103	624,209	29,235	24,368	17
18	21	Gen'l & Administrative	Patient days	31	6,168,666	5,291,904	29,235	147,502	18
19	6	Repairs & Maniten.	Patient days	31	882,577	685,666	29,235	21,104	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 16,659,561	\$ 10,594,764		\$ 398,825	25

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care (# 0040709 Report Period Beginning: 1/1/09 Ending: 12/31/09

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										
										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					\$	\$			\$	1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	Related party-AMS		x	working capital						38,013	6								
7	Related party-FECH		x							789	7								
8											8								
9	TOTAL Facility Related				\$	\$			\$	38,802	9								
B. Non-Facility Related*																			
10	Interest Income (4646/4975)		x							(8,309)	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related				\$	\$			\$	(8,309)	14								
15	TOTALS (line 9+line14)				\$	\$			\$	30,493	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.)

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

0040709

Report Period Beginning:

1/1/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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				\$	\$		\$	\$	\$	
5										
6										
7										
8	Related Party-Forum		1978	13,669		25			13,669	
	Improvement Type**									
9	Sprinkler heads		1995	1,832	73	25	73		1,043	
10	Roof repairs		1995	2,000		10			2,000	
11	Installed Electric AMPS		1996	1,870		5			1,870	
12	Signs		1996	1,800		10			1,800	
13	Water Heater		1997	6,180		5			6,180	
14	Replace Pipes		1997	5,949		5			5,949	
15	Exhaust Fans		1997	8,403		5			8,403	
16	Washing machine motor		1998	1,576		8			1,576	
17	ABC (General construction) Major repairs/improvement		1999	5,713	287	10	287		5,713	
18	ABC (General construction) Major repairs/improvement		1999	2,326	134	10	134		2,326	
19	ABC (General construction) Major repairs/improvement		1999	2,092	123	10	123		2,092	
20	ABC (General construction) Major repairs/improvement		1999	1,870	156	10	156		1,870	
21	ABC (General construction) Major repairs/improvement		1999	12,658	1,054	10	1,054		12,658	
22	ABC (General construction) Major repairs/improvement		1999	2,250	206	10	206		2,250	
23	ABC (General construction) Major repairs/improvement		1999	10,225	939	10	939		10,225	
24	Climate Services (exhaust fan)		1999	2,280		5			2,280	
25	Oxygen exhaust system		2000	8,555		8			8,555	
26	Elevator door repair		2000	1,518		5			1,518	
27	Lawn Sprinkler		2000	15,500	620	25	620		5,787	
28	ABC (General construction) Major repairs/improvement		2000	6,937		5			6,937	
29	ABC (General construction) New hot water system		2000	49,596	2,480	20	2,480		24,386	
30	ABC (General construction) Replace showers		2000	23,903	2,390	10	2,390		22,308	
31	Replace Fire Pump		2001	3,230	162	20	162		1,456	
32	14 Kilowatt water heater booster		2001	2,783	278	10	278		2,318	
33	ABC (General construction) Major repairs/improvement		2001	3,402		5			3,402	
34										
35										
36										

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

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

See Page 12A, Line 70 for total

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

0040709

Report Period Beginning:

1/1/09

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Capps Plumbing (pipe & wall repair)	2002	\$ 1,985	\$	5	\$	\$	\$ 1,985	37
38	ABC (misc construction work)	2002	3,442		5			3,442	38
39	ABC (repair ejector pump)	2002	7,893		5			7,893	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		1,216	40
41	TNS (DSL Cable)	2004	1,358	25	5	25		1,358	41
42	ABC (1st Floors Stairs)	2004	1,699	170	10	170		864	42
43	Oak Fire security System, new base dual zone card	2005	1,350	270	5	270		1,103	43
44	Washtown (repair Washer motor)	2005	1,563	313	5	313		1,382	44
45	ABC (repair Mop basin)	2005	1,613	323	5	323		1,426	45
46									46
47	ABC - seal holes and replace fill materials 3rd floor	2006	5,793	579	10	579		2,171	47
48	TopNotch - booster heater	2006	3,217	322	10	322		1,046	48
49									49
50	ABC - wall covering	2007	10,494	1,049	10	1,049		2,798	50
51									51
52	ABC - HM door and frame	2008	3,270	327	10	327		545	52
53	Central States - springkler system	2008	3,700	740	5	740		740	53
54	ABC - patio door	2008	2,501	250	10	250		313	54
55	ABC - repair electrical room and patio doors	2008	2,915	292	10	292		316	55
56									56
57	JD Roofing - asphalt roof patched	2009	3,600	120	10	120		120	57
58	Oak Fire - wirings for sprinkler system	2009	5,070	296	10	296		296	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 262,855	\$ 14,142		\$ 14,142	\$	\$ 187,585	70

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

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

0040709

Report Period Beginning:

1/1/09

Ending:

12/31/09

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		\$ 262,855	\$ 14,142		\$ 14,142	\$	\$ 187,585	1
2	Forum Prof Ctr: Remodeling	1979	16,169		20			16,169	2
3	Forum Prof Ctr: Build Improv - multiple	1980	10,322		15			10,322	3
4	Forum Prof Ctr: Tennant Improv	1986	836		13			836	4
5	Forum Prof Ctr: AMS remodel	1990	5,681		10			5,681	5
6	Forum Prof Ctr: Roof	1994	2,997	187	16	187		2,811	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,057	66	16	66		921	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,669	152	10	152		1,496	8
9	Forum Prof Ctr: Remodel/electrical	2001	650	36	7	36		543	9
10	Forum Prof Ctr: bathroom remodel	2002	575	54	5	54		427	10
11	Forum Prof Ctr: remodel suites/etc.	2003	739	75	9	75		516	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,275	244	7	244		1,765	12
13	Forum Prof Ctr: Suite renovation	2005	460	83	10	83		450	13
14	Forum Prof Ctr: Superior installations, etc.	2006	91	23	4	23		77	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	432	67	7	67		155	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	368	64	7	64		87	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	762	15	7	15		15	17
18	Alden Mgt Servs: Remodel suites	1993	5,555		7			5,555	18
19	Alden Mgt Servs: Remodel suites	2002	318	42	7	42		309	19
20	Alden Mgt Servs: Remodel suites	2003	8,987	1,238	7	1,238		8,765	20
21									21
22	Forum Ext Care, LLC-Building	1998	6,067	152	40	152		1,732	22
23	Forum Ext Care, LLC-Build Improv	1999	4,689	117	40	117		1,230	23
24	Forum Extended Care-Maj Eq Repair	2002	31		3			31	24
25	Forum Extended Care-Maj Plumbing Repair	2003	29		3			29	25
26	Forum Extended Care-Compressor	2004	20		3			20	26
27									27
28									28
29									29
30	adj for ABC related party profit	2008	(50)	(4)		(4)		(6)	30
31	adj for ABC related party profit	2009	(161)	(2)		(2)		(2)	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 333,422	\$ 16,751		\$ 16,751	\$	\$ 247,519	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	\$ 173,595	\$ 18,136	\$ 18,136	\$		\$ 96,211	71
72	Current Year Purchases	7,954	330	330			330	72
73	Fully Depreciated Assets	183,551	2,878	2,878			183,551	73
74								74
75	TOTALS	\$ 365,100	\$ 21,344	\$ 21,344	\$		\$ 280,092	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	98-02	4,415					4,415	79
80	TOTALS			\$ 4,415	\$	\$	\$		\$ 4,415	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)	\$ 702,937	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,095	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 38,095	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)	\$ 532,026	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: T.L. Enterprises

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

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:		<u>96</u>		\$ <u>502,366</u>	<u>16</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>96</u>		\$ <u>502,366</u>			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: Purchase Option Deposit *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 21,105 Description: copy mach gl 6861, postage meter gl 6850, & office equip gl 6859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>related party- AMS</u>	<u>various</u>	\$ <u>#####</u>	\$ <u>14,139</u>	17
18					18
19	<u>Auto lease GL 6890</u>	<u>various</u>	<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>14,139</u>	21

10. Effective dates of current rental agreement:

Beginning 03/01/95

Ending 02/28/13

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

Fiscal Year Ending Annual Rent

12. 12/31/2010 \$ 502,366

13. 12/31/2011 \$ 502,366

14. 12/31/2012 \$ 502,366

* 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?</p> <p><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 nursing 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	\$		\$ 133,025	\$		\$ 133,025	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,534			9,534	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			136,089			136,089	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				169,449		169,449	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Except Care Prgrm</u>	39-1, 39-3, if any								12
13	Other (specify): <u>See Pg 16A</u>					25,265	111,746		137,011	13
14	TOTAL			\$		\$ 303,913	\$ 281,195		\$ 585,108	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	\$133,025.00
2. ST	39-3	To Col 5	9,534.00
3.			
4. PT	39-3	To Col 5	136,089.00
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			123,589.00
Manual Input from Related Party- Forum Drugs			45,860.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	169,449.00
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	25,265.00
Other			163,121.00
Manual Input: Related Party - Prism			(32,880.00)
Manual Input: Related Party FECII - I.V.			(59,437.00)
Manual Input: Related Party FECII - Wound Care			(1,869.00)
Oxygen, from reclass worksheet			42,811.00
13. Col 6: Supplies Total		To Col 6	111,746.00
13. Total Line 13, Column 8			137,011.00
14. Total			585,108.00
			585,108.00
			0.00

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

0040709

Report Period Beginning: 1/1/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>101,964</u>)	947,255		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,006		6
7	Other Prepaid Expenses	2,568		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	48,352		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,002,181	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	353,396		15
16	Equipment, at Historical Cost	323,932		16
17	Accumulated Depreciation (book methods)	(476,739)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	204,241		21
22	Other Long-Term Assets (spe <u>Purchase Option</u>)	288,000		22
23	Other(specify): <u>Due from Affiliates</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 692,830	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,695,011	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 507,427	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	88,018		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,806		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,967		31
32	Accrued Real Estate Taxes(Sch.IX-B)	116,074		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accr Exp/Insur, Due State, Sales Tax, etc.</u>	197,926		36
37	<u>Due to Affiliates</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,123,218	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Affiliates</u>	567,232		43
44	<u>S/holder loans, Others</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 567,232	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,690,450	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,561	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,695,011	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,467)	1
2	Restatements (describe):		2
3	external audit adjustment made after 2008 cost report was		3
4	submitted. These have no effect on prior year's report:		4
5	Bad debt, Medicare revenues (non allowables)	(19,046)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (28,513)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,074	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)	\$ 33,074	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)	\$ 4,561	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center # 0040709 Report Period Beginning: 1/1/09

Ending: 12/31/09

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	\$ 5,021,125	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,021,125	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,720	6
7	Oxygen	35,036	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 134,756	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	205	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	21,424	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 21,629	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,309	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,309	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	see Pg19A	1,541	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,541	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,187,360	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	924,527	31
32	Health Care	1,677,298	32
33	General Administration	1,228,689	33
B. Capital Expense			
34	Ownership	705,854	34
C. Ancillary Expense			
35	Special Cost Centers	565,358	35
36	Provider Participation Fee	52,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,154,286	40
41	Income before Income Taxes (line 30 minus line 40)**	33,074	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 33,074	43

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

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Lincoln Rehabilitation & Health Care Center # 0040709 Report Period Beginning: 1/1/09 Ending: 12/31/09

Details of Page 19, Line 28

misc receipts (employee cost - reissue lost checks)	300.00
Medical records	234.00
Jury Duty	-
Food rebate	732.00
Rent - Polling site	275.00
	<hr/>
Total	<u><u>1,541.00</u></u>

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

0040709

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	1,920	1,989	\$ 67,909	\$ 34.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,081	9,601	296,332	30.86	3
4	Licensed Practical Nurses	15,317	16,100	405,646	25.20	4
5	CNAs & Orderlies	43,343	46,728	563,017	12.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,848	1,848	32,339	17.50	9
10	Activity Assistants	1,599	1,647	14,126	8.58	10
11	Social Service Workers	2,080	2,080	40,311	19.38	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,080	44,480	21.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,661	15,153	177,495	11.71	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	63,708	30.63	17
18	Housekeepers	8,189	9,258	101,160	10.93	18
19	Laundry	5,569	6,223	63,728	10.24	19
20	Administrator	2,056	2,080	84,253	40.51	20
21	Assistant Administrator					21
22	Other Administrative	3,200	3,200	84,715	26.47	22
23	Office Manager					23
24	Clerical	1,984	2,042	18,938	9.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,603	1,679	52,119	31.04	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Alzheimer Supervi	2,080	2,080	29,245	14.06	33
34	TOTAL (lines 1 - 33)	117,666	125,868	\$ 2,139,521 *	\$ 17.00	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	900/monthly	\$ 10,800	1-3	35
36	Medical Director	2250/monthly	27,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	192/monthly	2,304	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	86/monthly	1,036	11-3	44
45	Social Service Consultant	22/monthly	268	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,408		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

Legal Fees Reported on Pg 21, Section C:	8,517.00
Less: Collection, estates & other non-allowable legal fees listed on Pg 5, Ln 19	(5,395.00)
Less: Non-allowable legal fees, if any, deducted on Pg 5A	<hr/>
Allowable Legal Fees	<hr/> 3,122.00 <hr/>

NOTE:

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

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2	Climate Service - boil	1/96	2,015	15	134	134	134	134	134				
3	Great Lakes - plumbing fi	3/96	1,739	20	87	87	87	87	87	87	87	87	
4	Building Plumbing Heat	10/96	1,831	15	122	122	122	122	122	30			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,585		\$ 343	\$ 343	\$ 343	\$ 343	\$ 343	\$ 117	\$ 87	\$ 87	\$ 87

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. IHCA \$3,710, IL Assoc of HCF \$1,152
- (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. \$ 21,618 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. \$ 52,560
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. \$ 28,992 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? No
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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.