



Facility Name & ID Number Alden of Old Town East

# 0042069 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,231	351		5,582	13
14	TOTALS	5,231	351		5,582	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.58%

D. How many bed-hold days during this year were paid by the Department? 185 (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

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 of Old Town East # 0042069 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
	<b>A. General Services</b>										
1	Dietary	53,669	6,136		59,805	48	59,853	671	60,524		1
2	Food Purchase		42,055		42,055	(3,922)	38,133	1,236	39,369		2
3	Housekeeping	14,133	6,147		20,280	818	21,098	496	21,594		3
4	Laundry		5,460		5,460		5,460		5,460		4
5	Heat and Other Utilities			17,790	17,790		17,790	240	18,030		5
6	Maintenance	3,014		40,706	43,720	(482)	43,238	14,266	57,504		6
7	Other (specify):* <b>Related Party Benefits</b>							659	659		7
8	<b>TOTAL General Services</b>	70,816	59,798	58,496	189,110	(3,538)	185,572	17,568	203,140		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	386,025	17,433	2,236	405,694	770	406,464	5,469	411,933		10
10a	Therapy					5,507	5,507	(3,845)	1,662		10a
11	Activities		3,024	23,182	26,206		26,206		26,206		11
12	Social Services	34,278			34,278		34,278		34,278		12
13	CNA Training	6,163			6,163		6,163		6,163		13
14	Program Transportation										14
15	Other (specify):* <b>Related Party Benefits</b>							874	874		15
16	<b>TOTAL Health Care and Programs</b>	426,466	20,457	28,418	475,341	6,277	481,618	2,498	484,116		16
	<b>C. General Administration</b>										
17	Administrative	17,886			17,886		17,886	10,749	28,635		17
18	Directors Fees										18
19	Professional Services			87,839	87,839	(42)	87,797	(77,103)	10,694		19
20	Dues, Fees, Subscriptions & Promotions			4,881	4,881		4,881	(3,279)	1,602		20
21	Clerical & General Office Expenses	20,775	4,965	11,995	37,735	524	38,259	28,394	66,653		21
22	Employee Benefits & Payroll Taxes			73,236	73,236	2,286	75,522	(6)	75,516		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,280	2,280		2,280	109	2,389		24
25	Other Admin. Staff Transportation			3,360	3,360		3,360	1,295	4,655		25
26	Insurance-Prop.Liab.Malpractice			17,416	17,416		17,416	1,002	18,418		26
27	Other (specify):* <b>Related Party Benefits</b>			2,060	2,060		2,060	3,763	5,823		27
28	<b>TOTAL General Administration</b>	38,661	4,965	203,067	246,693	2,768	249,461	(35,076)	214,385		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	535,943	85,220	289,981	911,144	5,507	916,651	(15,010)	901,641		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 &amp; ID Number

Alden of Old Town East

#0042069

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			5,118	5,118		5,118	32,849	37,967			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,708	20,708		20,708	56,715	77,423			32
33	Real Estate Taxes							15,454	15,454			33
34	Rent-Facility & Grounds			95,091	95,091		95,091	(95,091)				34
35	Rent-Equipment & Vehicles			3,535	3,535		3,535	4,327	7,862			35
36	Other (specify):* M.I.P.							6,709	6,709			36
37	<b>TOTAL Ownership</b>			124,452	124,452		124,452	20,963	145,415			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		897	5,507	6,404	(5,507)	897	256	1,153			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,034	65,034		65,034		65,034			42
43	Other (specify):* day training			281,591	281,591		281,591		281,591			43
44	<b>TOTAL Special Cost Centers</b>		897	352,132	353,029	(5,507)	347,522	256	347,778			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	535,943	86,117	766,565	1,388,625		1,388,625	6,209	1,394,834			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:  
 Report Period Ending:

IDPH Facility ID Number: #0042069

1/1/2008  
 12/31/2008

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2	22	(3,922.00)	Employee Meals
		3,922.00	Employee Meals
22	10	(1,636.00)	Uniforms
	1	770.00	Uniforms
	3	48.00	Uniforms
	4	818.00	Uniforms
	6		Uniforms
	11		Uniforms
	21		Uniforms
21	6	482.00	Vendor Settlements
		(482.00)	Vendor Settlements
<u>Others, if any:</u>			
39	10A	(5,507.00)	PT, OT, & ST CPT Therapy Costs
		5,507.00	PT, OT, & ST CPT Therapy Costs
19	21	(42.00)	Medi-Com Software Services
		42.00	Medi-Com Software Services
Net		-	

**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	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(135)	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	(35)	21		17
18	Fines and Penalties	(64)	32		18
19	Entertainment				19
20	Contributions	(47)	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	(2,060)	27		24
25	Fund Raising, Advertising and Promotional	(3,178)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (5,532)		\$	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)	6,655	Various	34
35	Other- Attach Schedule	5,086	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 11,741		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 6,209		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Alden of Old Town East

ID# 0042069

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees on Utilities	\$ (62)	5	1
2	Intercompany Interest	(5,982)	32	2
3	Wage Service Fee	(6)	22	3
4	Food Rebate	(108)	2	4
5	Back out 30% of PAC fees from IHCA bills	(265)	20	5
6	Deming Training Cost	(310)	24	6
7	Elim Deprec on Pg 13 < \$2,500 items	(1,242)	30	7
8	Expense Pg 13 items < \$2,500 Curr Yr	7,844	6	8
9	Expense Pg 13 items < \$2,500	516	6	9
10	Elim Deprec on Pg 12 < \$2,500 items	(275)	30	10
11	Expense Pg 12 items < \$2,500 Curr Yr	5,082	6	11
12	Expense Pg 12 items < \$2,500	270	6	12
13	Adj for ABC related party profit '09 - Pg 12	(5)	30	13
14	Adj for ABC related party profit '09 - Pg 13	(3)	30	14
15	Adjust Depreciation to Pg 13	(368)	30	15
16				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	<b>Total</b>	5,086		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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	671	0	0	0	0	0	0	0	0	671	1
2	Food Purchase	(243)	0	0	1,479	0	0	0	0	0	0	0	1,236	2
3	Housekeeping	0	0	496	0	0	0	0	0	0	0	0	496	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(62)	0	302	0	0	0	0	0	0	0	0	240	5
6	Maintenance	13,712	0	714	0	0	0	(160)	0	0	0	0	14,266	6
7	Other (specify):*	0	0	653	6	0	0	0	0	0	0	0	659	7
8	<b>TOTAL General Services</b>	<b>13,407</b>	<b>0</b>	<b>2,836</b>	<b>1,485</b>	<b>0</b>	<b>0</b>	<b>(160)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>17,568</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	5,257	65	147	0	0	0	0	0	0	5,469	10
10a	Therapy	0	0	0	0	0	(3,845)	0	0	0	0	0	(3,845)	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	874	0	0	0	0	0	0	0	0	874	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>6,131</b>	<b>65</b>	<b>147</b>	<b>(3,845)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,498</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	10,749	0	0	0	0	0	0	0	0	10,749	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,712	(79,815)	0	0	0	0	0	0	0	0	(77,103)	19
20	Fees, Subscriptions & Promotions	(3,490)	150	61	0	0	0	0	0	0	0	0	(3,279)	20
21	Clerical & General Office Expenses	(35)	0	28,180	133	116	0	0	0	0	0	0	28,394	21
22	Employee Benefits & Payroll Taxes	(6)	0	0	0	0	0	0	0	0	0	0	(6)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(310)	0	419	0	0	0	0	0	0	0	0	109	24
25	Other Admin. Staff Transportation	0	0	1,295	0	0	0	0	0	0	0	0	1,295	25
26	Insurance-Prop.Liab.Malpractice	0	984	18	0	0	0	0	0	0	0	0	1,002	26
27	Other (specify):*	(2,060)	0	5,822	17	(16)	0	0	0	0	0	0	3,763	27
28	<b>TOTAL General Administration</b>	<b>(5,901)</b>	<b>3,846</b>	<b>(33,271)</b>	<b>150</b>	<b>100</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(35,076)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>7,506</b>	<b>3,846</b>	<b>(24,304)</b>	<b>1,700</b>	<b>247</b>	<b>(3,845)</b>	<b>(160)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(15,010)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(1,893)	30,512	2,864	0	1,366	0	0	0	0	0	0	32,849	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,059)	55,506	7,262	0	6	0	0	0	0	0	0	56,715	32
33	Real Estate Taxes	0	14,879	574	0	1	0	0	0	0	0	0	15,454	33
34	Rent-Facility & Grounds	0	(95,091)	0	0	0	0	0	0	0	0	0	(95,091)	34
35	Rent-Equipment & Vehicles	0	0	4,327	0	0	0	0	0	0	0	0	4,327	35
36	Other (specify):*	0	6,709	0	0	0	0	0	0	0	0	0	6,709	36
37	<b>TOTAL Ownership</b>	<b>(7,952)</b>	<b>12,515</b>	<b>15,027</b>	<b>0</b>	<b>1,373</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>20,963</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	174	82	0	0	0	0	0	0	256	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>174</b>	<b>82</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>256</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(446)	16,361	(9,277)	1,874	1,702	(3,845)	(160)	0	0	0	0	6,209	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	\$ 95,091	Alden of Bloomingdale Limited Partnership	0.00%	\$	\$ (95,091)	1
2	V	32 Interest Income	14,371	Alden of Bloomingdale Limited Partnership			(14,371)	2
3	V	32 Interest Income - RR	39	Alden of Bloomingdale Limited Partnership			(39)	3
4	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		2,487	2,487	4
5	V	19 Professional Fees		Alden of Bloomingdale Limited Partnership		225	225	5
6	V	20 Dues & Subscriptions		Alden of Bloomingdale Limited Partnership		150	150	6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		14,879	14,879	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		984	984	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		6,709	6,709	9
10	V	32 Interest - Other		Alden of Bloomingdale Limited Partnership		45,762	45,762	10
11	V	32 Interest - IOD		Alden of Bloomingdale Limited Partnership		21,737	21,737	11
12	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		30,512	30,512	12
13	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		2,417	2,417	13
14	Total		\$ 109,501			\$ 125,862	\$ * 16,361	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%	\$ 302	\$	302	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		419		419	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,295		1,295	17
18	V	26 Insurance		Alden Management Services, Inc.		18		18	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		61		61	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,864		2,864	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		574		574	21
22	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		4,327		4,327	22
23	V	32 Interest		Alden Management Services, Inc.		7,262		7,262	23
24	V	1 Dietary		Alden Management Services, Inc.		671		671	24
25	V	3 Houskeeping		Alden Management Services, Inc.		496		496	25
26	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		653		653	26
27	V	10 Nursing & Medical Records Salaries		Alden Management Services, Inc.		5,257		5,257	27
28	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		874		874	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		10,749		10,749	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		5,822		5,822	30
31	V	19 Professional Fees	84,470	Alden Management Services, Inc.		4,655		(79,815)	31
32	V	21 General & Administrative		Alden Management Services, Inc.		28,180		28,180	32
33	V	6 Repairs & Maintenance	3,318	Alden Management Services, Inc.		4,032		714	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 87,788			\$ 78,511	\$ *	(9,277)	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	\$ 500	Prism Health Care Services, Inc.	0.00%	\$ 1,979	\$ 1,479	15
16	V	10 Equipment Rental	360	Prism Health Care Services, Inc.		425	65	16
17	V	39 Ancillary Supplies	176	Prism Health Care Services, Inc.		350	174	17
18	V	21 Gen'l & Admin Salary		Prism Health Care Services, Inc.		87	87	18
19	V	27 Employee Benefits		Prism Health Care Services, Inc.		17	17	19
20	V	7 Employee Benefits		Prism Health Care Services, Inc.		6	6	20
21	V	21 General & Administrative		Prism Health Care Services, Inc.		46	46	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,036			\$ 2,910	\$ * 1,874	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	\$ 220	Forum Extended Care Services II, Inc.	0.00%	\$ 302	\$ 82	15
16	V	10 House Stock	780	Forum Extended Care Services II, Inc.		708	(72)	16
17	V	10 Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		603	219	17
18	V	27 Employee Vaccination	117	Forum Extended Care Services II, Inc.		92	(25)	18
19	V	27 Employee Benefits: G & A		Forum Extended Care Services II, Inc.		9	9	19
20	V	21 Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		74	74	20
21	V	21 Gen'l & Admin.		Forum Extended Care Services II, Inc.		42	42	21
22	V	32 Interest		Forum Extended Care Services II, Inc.		6	6	22
23	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		1	1	23
24	V	30 Depreciation		Forum Extended Care Services II, Inc.		1,366	1,366	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,501			\$ 3,203	\$ * 1,702	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	\$ 5,507	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,662	\$ (3,845)
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		\$ 5,507			\$ 1,662	\$ * (3,845)

\* 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	\$ 12,171	Alden Bennett Construction Company, Inc.	0.00%	\$ 12,011	\$ (160)
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		\$ 12,171			\$ 12,011	\$ * (160)

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

Facility Name &amp; ID Number Alden of Old Town East

Provider No. 0042069

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 of Old Town East # 0042069 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	184,155	0.184	0.46	Salary	\$ 845	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,326	0.184	0.46	Salary	314	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,339	0.184	0.46	Salary	181	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	\$ 1,340		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:

1/1/09

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	\$	5,582	\$ 302	1
2	24	Travel/Seminar	patient days*	31	91,753		5,582	419	2
3	25	Other Admin Travel	patient days*	31	283,487		5,582	1,295	3
4	26	Insurance	patient days*	31	3,990		5,582	18	4
5	20	Dues/Subscriptions	patient days*	31	13,454		5,582	61	5
6	30	Depreciation	no. of providers	31	102,169		1	2,864	6
7	33	Real Estate Tax	patient days*	31	139,876		5,582	574	7
8	35	Rent-Equip/Vehicle	patient days*	31	947,116		5,582	4,327	8
9	32	Interest	patient days*	31	1,339,694		5,582	7,262	9
10	1	Dietary Salary	patient days*	31	146,892	146,892	5,582	671	10
11	3	Housekeeping Salary	patient days*	31	108,487	108,487	5,582	496	11
12	7	Employee Benef-Gen'l Servs	patient days*	31	142,881		5,582	653	12
13	10	Nurs/Med Rec Salary	patient days*	31	1,259,741	1,259,741	5,582	5,257	13
14	15	Employee Benef-Health Care	patient days*	31	191,270		5,582	874	14
15	17	Administrative Salary	patient days*	31	2,477,865	2,477,865	5,582	10,749	15
16	27	Employee Benef-Administrative	patient days*	31	1,274,479		5,582	5,822	16
17	19	Professional Fees	patient days*	31	1,019,103	624,209	5,582	4,655	17
18	21	Gen'l & Admin	patient days*	31	6,168,666	5,291,904	5,582	28,180	18
19	6	Repair & Mainten.	patient days*	31	882,577	685,666	5,582	4,032	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 16,659,561	\$ 10,594,764		\$ 78,511	25

Facility Name & ID Number

Alden of Old Town East

# 0042069

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Cambridge		x	Operating Loss Loan	\$2,122.33	6/02	\$ 339,267	\$ 316,543	09/2037	6.8600	\$ 21,737	1						
2	Cambridge			Mortgage	\$4,506.29	9/03	873,700	828,199	08/2043	5.5000	45,762	2						
3												3						
4	Amortization-Fin/Refin Fee		x	Financing							2,417	4						
5	Insurance Interest		x	Medical Malpractice							291	5						
<b>Working Capital</b>																		
6	Related party-AMS	x		working capital							7,262	6						
7	Related party-FECH	x		working capital							6	7						
8												8						
9	TOTAL Facility Related				\$6,628.62		\$ 1,212,967	\$ 1,144,742			\$ 77,475	9						
<b>B. Non-Facility Related*</b>																		
10	Interest		x	Replacement Reserve							(39)	10						
11	Interest Inc (Corp)		x	Patient Interest							(13)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (52)	14						
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,144,742			\$ 77,423	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,709 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.)





Facility Name & ID Number Alden of Old Town East

# 0042069

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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).

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

Facility Name & ID Number Alden of Old Town East

# 0042069

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1997	1997	934,861	23,372	40	23,372		269,394	4
5											5
6											6
7											7
8		Related Party-Forum		1978	13,669		25			13,669	8
		Improvement Type**									
9		TV Modules		1999	1,775		5			1,775	9
10		Sprinkler system		2001	2,345	235	10	235		2,034	10
11											11
12		ABC Counter Tops		2003	8,091	809	10	809		5,461	12
13		ABC roof repair		2003	1,685	168	10	168		1,024	13
14											14
15		Central States Automati(Sprinkler Repair)		2005	1,614	161	10	161		779	15
16		Alden Bennett Const(Door Installation)		2005	1,882	188	10	188		862	16
17											17
18		ABC - Replace Resident's Room Ceiling		2009	4,749	360	10	360		360	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

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 970,671	\$ 25,293		\$ 25,293	\$	\$ 295,358	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	Adjust for ABC Related Party Profit	2009	(63)	(5)		(5)		(5)	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,041,387	\$ 27,902		\$ 27,902	\$	\$ 355,295	34

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

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	\$ 103,005	\$ 8,872	\$ 8,872			\$ 75,996	71
72	Current Year Purchases	8,238	562	562			562	72
73	Fully Depreciated Assets	90,798	604	604			90,798	73
74								74
75	TOTALS	\$ 202,041	\$ 10,038	\$ 10,038			\$ 167,356	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	27	27		5	817	78
79	Related Party - AMS	Various	'98-'04	4,563				3	4,563	79
80	TOTALS			\$ 10,014	\$ 27	\$ 27			\$ 10,014	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)	\$ 1,404,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 37,967	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,967	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)	\$ 532,665	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: related party cost is backed out

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

If NO, see instructions.  YES  NO

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

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.	<u>/2010</u>	\$ <u>Varies</u>
13.	<u>/2011</u>	\$ <u>Varies</u>
14.	<u>/2012</u>	\$ <u>Varies</u>

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 3,535 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>225.08</u>	\$ <u>2,701</u>	17
18					18
19			<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>225.08</u>	\$ <u>2,701</u>	21

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

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

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 1/1/09 Ending: 12/31/09

**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 checked="" type="checkbox"/> YES <input 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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox" value="9"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>28</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox" value="8"/></p> <p>HOURS PER CNA <u>59</u></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)		2,168		2,168
4	Clinical Wages (b)	595	3,400		3,995
5	In-House Trainer Wages (c)			333	333
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 595	\$ 5,568	\$ 333	\$ 6,496
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,163			

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

**C. CONTRACTUAL INCOME**

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

\$ N/A

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>9</b>

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

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

	Service	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				302		302	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>						850		850	13
14	TOTAL			\$		\$	\$ 1,153		\$ 1,153	14

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

Page 16

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

## XIV. Special Services (Direct Cost)

Line	Service	Col. 1:	Ref. No.	To Pg 16:	Col. No.	
1.	OT		39-3	To Col 5		\$937.94
2.	ST		39-3	To Col 5		1,482.48
3.						
4.	PT		39-3	To Col 5		3,086.79
5.						
6.						
7.						
8.	Less PT, OT, & ST costs reclassified to Ln 10A for "DD" type facilities					(5,507.21)
	Pharmacy Supplies per GL					220.32
	Manual Input from Related Party- Forum Drugs					82.00
9.	Total to line 9 Pharmacy		See Pg 16A	To Col 6		302.32
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					676.48
	Manual Input: Related Party - Prism					174.00
	Manual Input: Related Party FECII - I.V.					
	Manual Input: Related Party FECII - Wound Care					
	Oxygen, from reclass worksheet (Pg 4A)					
13.	Col 6: Supplies Total			To Col 6		850.48
13.	Total Line 13, Column 8					850.48
14.	Total					1,152.80

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>1,500</u> )	191,712	191,712	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,093	6
7	Other Prepaid Expenses	1,317	1,317	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	8,907	8,907	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 201,936	\$ 207,029	10
	<b>B. Long-Term Assets</b>			
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	25,953	31,951	15
16	Equipment, at Historical Cost	54,128	156,346	16
17	Accumulated Depreciation (book methods)	(62,357)	(394,899)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		43,700	21
22	Other Long-Term Assets (spe <u>Refinance Fees</u>		16,305	22
23	Other(specify): <u>Due from Affiliates</u>	883,587	1,101,982	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 901,311	\$ 2,033,735	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,103,247	\$ 2,240,764	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 145,385	\$ 142,933	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,966	5,966	28
29	Short-Term Notes Payable		12,713	29
30	Accrued Salaries Payable	33,004	33,004	30
	Accrued Taxes Payable (excluding real estate taxes)	5,681	5,681	31
32	Accrued Real Estate Taxes(Sch.IX-B)		14,667	32
33	Accrued Interest Payable	1,191	5,598	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accr Exp/Insur, Due State, Sales Tax, etc.</u>	20,689	20,689	36
37	<u>Due to Affiliates</u>			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 211,916	\$ 241,251	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		312,572	39
40	Mortgage Payable		819,456	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Affiliates</u>			43
44	<u>S/holder loans, Others</u>			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 1,132,028	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 211,916	\$ 1,373,279	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 891,331	\$ 867,485	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,103,247	\$ 2,240,764	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 774,324	1
2	Restatements (describe):		2
3	External audit adjustment made after 2008 cost report		3
4	was submitted. These have no effect on prior year's report:		4
5	Fines, Penalties, & Unallowable Costs	13,688	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 788,012	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	103,319	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 103,319</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 891,331</b>	<b>24</b> *

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

Facility Name & ID Number Alden of Old Town East

# 0042069

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,197,801	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,197,801	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8,907	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,907	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 13	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Pg 19A	285,223	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 285,223	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,491,944	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	189,110	31
32	Health Care	475,341	32
33	General Administration	246,693	33
<b>B. Capital Expense</b>			
34	Ownership	124,452	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	287,995	35
36	Provider Participation Fee	65,034	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,388,625	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	103,319	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 103,319	43

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

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

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

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

**Details of Page 19, Line 28**

**Description**

**Amount**

Late Fee

Misc Income - Food Rebate

108

Misc Income - Wage Service Fee

6

Gain on Sale of Assets

3,518

Day Training

281,591

Line 28 Total:

\$ 285,223

Facility Name & ID Number Alden of Old Town East

# 0042069

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
2	Assistant Director of Nursing				2
3	Registered Nurses	3,060	95,951	31.36	3
4	Licensed Practical Nurses	1,571	43,167	27.48	4
5	CNAs & Orderlies				5
6	CNA Trainees	725	6,163	8.50	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	129	2,586	19.89	13
14	Head Cook	3,791	47,228	12.32	14
15	Cook Helpers/Assistants	316	3,854	12.20	15
16	Dishwashers				16
17	Maintenance Workers	130	3,014	23.18	17
18	Housekeepers	1,457	14,133	9.70	18
19	Laundry				19
20	Administrator	559	15,533	27.79	20
21	Assistant Administrator	78	2,353	30.17	21
22	Other Administrative	165	6,160	34.22	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)	1,913	34,278	17.92	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	22,075	246,908	10.53	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) Facility Manager	880	14,615	16.61	33
34	TOTAL (lines 1 - 33)	36,849	\$ 535,943 *	\$ 14.00	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	\$		35
36	Medical Director	250/Month	3,000	10-3
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	32/Month	384	10-3
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	414	22,348	11-3
45	Social Service Consultant	13	666	11-3
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	427	\$ 26,398	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53



Facility Name & ID Number Alden of Old Town East

Report Period Beginning: 1/1/09

Ending:

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	Painting	02/06	\$ 2,675	3	\$ 742	\$ 892	\$ 892	\$ 149	\$	\$	\$	\$	\$
2	Painting	05/09	3,300	3				733	1,100	1,100	367		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,975		\$ 742	\$ 892	\$ 892	\$ 882	\$ 1,100	\$ 1,100	\$ 367	\$	\$

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Health Care Assoc = \$618
- (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. \$ 6,613 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. \$ 65,034  
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. \$ 3,922 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: \_\_\_\_\_
- (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.