

Facility Name & ID Number Alden of Old Town West

0042077 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 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,699			5,699	13
14	TOTALS	5,699			5,699	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.59%

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

84 (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 05/19/98

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

ACCURAL 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 West # 0042077 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	63,731	3,775		67,506	219	67,725	685	68,410		1
2	Food Purchase		42,572		42,572	(3,927)	38,645	(137)	38,508		2
3	Housekeeping	14,573	6,923		21,496		21,496	506	22,002		3
4	Laundry		6,443		6,443		6,443		6,443		4
5	Heat and Other Utilities			17,160	17,160		17,160	347	17,507		5
6	Maintenance	3,014		34,585	37,599	(305)	37,294	11,813	49,107		6
7	Other (specify):* Related Party Benefits							668	668		7
8	TOTAL General Services	81,318	59,713	51,745	192,776	(4,013)	188,763	13,882	202,645		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	411,830	23,279	2,139	437,248	1,462	438,710	5,547	444,257		10
10a	Therapy					6,899	6,899	(4,964)	1,935		10a
11	Activities			23,515	23,515		23,515		23,515		11
12	Social Services	31,637			31,637		31,637		31,637		12
13	CNA Training	5,062			5,062		5,062		5,062		13
14	Program Transportation										14
15	Other (specify):* Related Party Benefits							892	892		15
16	TOTAL Health Care and Programs	448,529	23,279	28,654	500,462	8,361	508,823	1,475	510,298		16
	C. General Administration										
17	Administrative	17,886			17,886		17,886	10,974	28,860		17
18	Directors Fees										18
19	Professional Services			95,653	95,653	(42)	95,611	(85,480)	10,131		19
20	Dues, Fees, Subscriptions & Promotions			4,800	4,800		4,800	(3,196)	1,604		20
21	Clerical & General Office Expenses	21,531	2,022	19,820	43,373	347	43,720	21,811	65,531		21
22	Employee Benefits & Payroll Taxes			78,508	78,508	2,246	80,754		80,754		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,685	1,685		1,685	273	1,958		24
25	Other Admin. Staff Transportation			2,882	2,882		2,882	1,322	4,204		25
26	Insurance-Prop.Liab.Malpractice			17,416	17,416		17,416	1,003	18,419		26
27	Other (specify):* Related Party Benefits			(600)	(600)		(600)	6,482	5,882		27
28	TOTAL General Administration	39,417	2,022	220,164	261,603	2,551	264,154	(46,811)	217,343		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	569,264	85,014	300,563	954,841	6,899	961,740	(31,454)	930,286		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 of Old Town West

#0042077

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			3,895	3,895		3,895	32,851	36,746			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,801	20,801		20,801	56,777	77,578			32
33	Real Estate Taxes							15,467	15,467			33
34	Rent-Facility & Grounds			95,091	95,091		95,091	(95,091)				34
35	Rent-Equipment & Vehicles			3,535	3,535		3,535	4,417	7,952			35
36	Other (specify):* M.I.P.							6,709	6,709			36
37	TOTAL Ownership			123,322	123,322		123,322	21,130	144,452			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		195	6,899	7,094	(6,899)	195	64	259			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,730	72,730		72,730		72,730			42
43	Other (specify):* day training			306,490	306,490		306,490		306,490			43
44	TOTAL Special Cost Centers		195	386,119	386,314	(6,899)	379,415	64	379,479			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	569,264	85,209	810,004	1,464,477		1,464,477	(10,260)	1,454,217			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 West
 Reclassifications on Pgs 3 & 4 - Column 5
 Report Period Beginning:
 Report Period Ending:

IDPH Facility ID Number: #0042077

1/1/2008
 12/31/2008

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2	22	(3,927.00)	Employee Meals
		3,927.00	Employee Meals
22	10	(1,681.00)	Uniforms
	1	1,462.00	Uniforms
	3	219.00	Uniforms
	4		Uniforms
	6		Uniforms
	11		Uniforms
	21		Uniforms
21	6	305.00	Vendor Settlements
		(305.00)	Vendor Settlements
<u>Others, if any:</u>			
19	21	(42.00)	Medi-Com Software Services
		42.00	Medi-Com Software Services
39	10A	(6,899.00)	PT, OT, & ST CPT Therapy Costs
		6,899.00	PT, OT, & ST CPT Therapy Costs
Net		-	

Alden of Old Town West

ID# 0042077

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fee on Utilities	\$ 39	5	1
2	Inercompany Interest	(6,015)	32	2
3	Jury Duty	(17)	21	3
4	Food Rebate	(137)	2	4
5	Back out 30% of PAC fees from IHCA bills	(265)	20	5
6	Deming Training Cost	(155)	24	6
7	Elim Deprec on Pg 13 < \$2,500 items	(1,002)	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	(217)	30	10
11	Expense Pg 12 items < \$2,500 Curr Yr	3,314	6	11
12	Expense Pg 12 items < \$2,500	270	6	12
13	Adj for ABC related party profit '09 - Pg 13	(3)	30	13
14	Adjust Depreciation to Pg 13	(669)	30	14
15	Eliminate IDPH Vendor Settlement	(7,150)	21	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	Total	(3,647)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town West

0042077

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	685	0	0	0	0	0	0	0	0	685	1
2	Food Purchase	(137)	0	0	0	0	0	0	0	0	0	0	(137)	2
3	Housekeeping	0	0	506	0	0	0	0	0	0	0	0	506	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	39	0	308	0	0	0	0	0	0	0	0	347	5
6	Maintenance	11,944	0	(30)	0	0	0	(101)	0	0	0	0	11,813	6
7	Other (specify):*	0	0	666	2	0	0	0	0	0	0	0	668	7
8	TOTAL General Services	11,846	0	2,135	2	0	0	(101)	0	0	0	0	13,882	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	5,368	65	114	0	0	0	0	0	0	5,547	10
10a	Therapy	0	0	0	0	0	(4,964)	0	0	0	0	0	(4,964)	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	892	0	0	0	0	0	0	0	0	892	15
16	TOTAL Health Care and Programs	0	0	6,260	65	114	(4,964)	0	0	0	0	0	1,475	16
	C. General Administration													
17	Administrative	0	0	10,974	0	0	0	0	0	0	0	0	10,974	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,712	(88,192)	0	0	0	0	0	0	0	0	(85,480)	19
20	Fees, Subscriptions & Promotions	(3,409)	150	63	0	0	0	0	0	0	0	0	(3,196)	20
21	Clerical & General Office Expenses	(7,167)	0	28,770	46	162	0	0	0	0	0	0	21,811	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(155)	0	428	0	0	0	0	0	0	0	0	273	24
25	Other Admin. Staff Transportation	0	0	1,322	0	0	0	0	0	0	0	0	1,322	25
26	Insurance-Prop.Liab.Malpractice	0	984	19	0	0	0	0	0	0	0	0	1,003	26
27	Other (specify):*	600	0	5,944	6	(68)	0	0	0	0	0	0	6,482	27
28	TOTAL General Administration	(10,131)	3,846	(40,672)	52	94	0	0	0	0	0	0	(46,811)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	1,715	3,846	(32,277)	119	208	(4,964)	(101)	0	0	0	0	(31,454)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town West

0042077

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)	
	D. Ownership													
30	Depreciation	(1,891)	30,512	2,864	0	1,366	0	0	0	0	0	0	32,851	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,152)	55,506	7,415	0	8	0	0	0	0	0	0	56,777	32
33	Real Estate Taxes	0	14,879	586	0	2	0	0	0	0	0	0	15,467	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	4,417	0	0	0	0	0	0	0	0	4,417	35
36	Other (specify):*	0	6,709	0	0	0	0	0	0	0	0	0	6,709	36
37	TOTAL Ownership	(8,043)	12,515	15,282	0	1,376	0	0	0	0	0	0	21,130	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	64	0	0	0	0	0	0	64	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	64	0	0	0	0	0	0	64	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(6,328)	16,361	(16,995)	119	1,648	(4,964)	(101)	0	0	0	0	(10,260)	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%	\$ 308	\$	308	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		428		428	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,322		1,322	17
18	V	26 Insurance		Alden Management Services, Inc.		19		19	18
19	V	20 Dues & Subscriptions		Alden Management Services, Inc.		63		63	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,864		2,864	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		586		586	21
22	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		4,417		4,417	22
23	V	32 Interest		Alden Management Services, Inc.		7,415		7,415	23
24	V	1 Dietary		Alden Management Services, Inc.		685		685	24
25	V	3 Houskeeping		Alden Management Services, Inc.		506		506	25
26	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		666		666	26
27	V	10 Nursing & Medical Records Salaries		Alden Management Services, Inc.		5,368		5,368	27
28	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		892		892	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		10,974		10,974	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		5,944		5,944	30
31	V	19 Professional Fees	92,945	Alden Management Services, Inc.		4,753		(88,192)	31
32	V	21 General & Administrative		Alden Management Services, Inc.		28,770		28,770	32
33	V	6 Repairs & Maintenance	4,146	Alden Management Services, Inc.		4,116		(30)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 97,091			\$ 80,096	\$ *	(16,995)	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	10 Equipment Rental	\$ 360	Prism Health Care Services, Inc.	0.00%	\$ 425	\$ 65	15	
16	V	21 Gen'l & Admin Salary		Prism Health Care Services, Inc.		30	30	16	
17	V	27 Employee Benefits		Prism Health Care Services, Inc.		6	6	17	
18	V	7 Employee Benefits		Prism Health Care Services, Inc.		2	2	18	
19	V	21 General & Administrative		Prism Health Care Services, Inc.		16	16	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		\$ 360			\$ 479	\$ *	119	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	\$ 180	Forum Extended Care Services II, Inc.	0.00%	\$ 247	\$ 67	15
16	V	39 Wound Care	15	Forum Extended Care Services II, Inc.		12	(3)	16
17	V	10 House Stock	1,127	Forum Extended Care Services II, Inc.		1,022	(105)	17
18	V	10 Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		603	219	18
19	V	27 Employee Vaccination	381	Forum Extended Care Services II, Inc.		301	(80)	19
20	V	27 Employee Benefits: G & A		Forum Extended Care Services II, Inc.		12	12	20
21	V	21 Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		103	103	21
22	V	21 Gen'l & Admin.		Forum Extended Care Services II, Inc.		59	59	22
23	V	32 Interest		Forum Extended Care Services II, Inc.		8	8	23
24	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		2	2	24
25	V	30 Depreciation		Forum Extended Care Services II, Inc.		1,366	1,366	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		\$ 2,087			\$ 3,735	\$ * 1,648	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	\$ 6,899	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 1,935	\$ (4,964)
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		\$ 6,899			\$ 1,935	\$ * (4,964)

* 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	\$ 7,606	Alden Bennett Construction Company, Inc.	0.00%	\$ 7,505	\$	(101)	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		\$ 7,606			\$ 7,505	\$ *	(101)	39

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

Facility Name & ID Number Alden of Old Town West

Provider No. 0042077

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 West # 0042077 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	184,137	0.188	0.47	Salary	\$ 863	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,320	0.188	0.47	Salary	320	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,336	0.188	0.47	Salary	184	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	\$ 1,367		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 West

0042077

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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	\$	5,699	\$ 308	1
2	24	Travel/Seminar	patient days*	31	91,753		5,699	428	2
3	25	Other Admin Travel	patient days*	31	283,487		5,699	1,322	3
4	26	Insurance	patient days*	31	3,990		5,699	19	4
5	20	Dues/Subscriptions	patient days*	31	13,454		5,699	63	5
6	30	Depreciation	no. of providers	31	102,169		1	2,864	6
7	33	Real Estate Tax	patient days*	31	139,876		5,699	586	7
8	35	Rent-Equip/Vehicle	patient days*	31	947,116		5,699	4,417	8
9	32	Interest	patient days*	31	1,339,694		5,699	7,415	9
10	1	Dietary Salary	patient days*	31	146,892	146,892	5,699	685	10
11	3	Housekeeping Salary	patient days*	31	108,487	108,487	5,699	506	11
12	7	Employee Benef-Gen'l Servs	patient days*	31	142,881		5,699	666	12
13	10	Nurs/Med Rec Salary	patient days*	31	1,259,741	1,259,741	5,699	5,368	13
14	15	Employee Benef-Health Care	patient days*	31	191,270		5,699	892	14
15	17	Administrative Salary	patient days*	31	2,477,865	2,477,865	5,699	10,974	15
16	27	Employee Benef-Administrative	patient days*	31	1,274,479		5,699	5,944	16
17	19	Professional Fees	patient days*	31	1,019,103	624,209	5,699	4,753	17
18	21	Gen'l & Admin	patient days*	31	6,168,666	5,291,904	5,699	28,770	18
19	6	Repair & Mainten.	patient days*	31	882,577	685,666	5,699	4,116	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 16,659,561	\$ 10,594,764		\$ 80,096	25

Facility Name & ID Number

Alden of Old Town West

0042077

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
	A. Directly Facility Related																		
	Long-Term																		
1	Cambridge		x	Operating Loss Loan	\$2,122.33	6/02	\$ 339,267	\$ 316,543	09/2037	6.8600	\$ 21,737	1							
2	Cambridge		x	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							
	Working Capital																		
6	Related party-AMS	x		working capital							7,415	6							
7	Related party-FECH	x		working capital							8	7							
8												8							
9	TOTAL Facility Related				\$6,628.62		\$ 1,212,967	\$ 1,144,742			\$ 77,630	9							
	B. Non-Facility Related*																		
10	Interest - Repl Reserve		x								(39)	10							
11	Interest Inc (Corp)		x								(13)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (52)	14							
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,144,742			\$ 77,578	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 West

0042077

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>18,000</u>	<u>1995</u>	<u>\$ 150,868</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	18,000		\$ 150,868	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1998	1998	934,861	23,372	40	23,372		246,025	4
5										5
6										6
7										7
8	Related Party-Forum		1978	13,669		25			13,669	8
	Improvement Type**									
9	Sprinkler system		1999	1,510	101	15	101		1,100	9
10	ABC-counter tops		2004	8,102	810	10	810		5,468	10
11	ABC-Installed Dining Room Flooring		2005	5,421	361	15	361		1,595	11
12	ABC-Kitchen Repairs		2005	6,146	410	15	410		1,844	12
13										13
14										14
15										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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden of Old Town West

0042077

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		\$ 969,709	\$ 25,053		\$ 25,053	\$	\$ 269,701	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									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,040,488	\$ 27,668		\$ 27,668	\$	\$ 329,643	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	\$ 98,747	\$ 7,835	\$ 7,835	\$		\$ 72,986	71
72	Current Year Purchases	16,515	656	656			656	72
73	Fully Depreciated Assets	91,891	587	587			91,891	73
74								74
75	TOTALS	\$ 207,153	\$ 9,078	\$ 9,078	\$		\$ 165,533	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	Bus transfer from AMS	Bus	2001	\$ 16,646	\$	\$	\$	5	\$ 16,646	76
77										77
78										78
79	Related Party-AMS	Various	'98 - '02	4,415				3	4,415	79
80	TOTALS			\$ 21,061	\$	\$	\$		\$ 21,061	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)	\$ 1,419,570	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,746	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,746	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)	\$ 516,237	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions.

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

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

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

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

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: \$ 3,941 Description: Copy Machine Lease & Various Office Equipment

(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>229.83</u>	\$ <u>2,758</u>	17
18					18
19			<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>229.83</u>	\$ <u>2,758</u>	21

10. Effective dates of current rental agreement:

Beginning 12/02/1996

Ending 11/30/2036

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

Fiscal Year Ending Annual Rent

12. /2010 \$ varies

13. /2011 \$ varies

14. /2012 \$ varies

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox" value="6"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>28</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox" value="6"/></p> <p>HOURS PER CNA <u>72</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)		1,407		1,407
4	Clinical Wages (b)	255	3,400		3,655
5	In-House Trainer Wages (c)			223	223
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 255	\$ 4,807	\$ 223	\$ 5,285
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,062			

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	<u>5</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	
TOTAL TRAINED	6

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				247		247	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>						12		12	13
14	TOTAL			\$		\$	259		\$ 259	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)

Page 16

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

Line	Service	Col. 1:	Ref. No.	To Pg 16:	Col. No.	
1.	OT		39-3	To Col 5		\$952.85
2.	ST		39-3	To Col 5		1,722.53
3.						
4.	PT		39-3	To Col 5		4,224.06
5.						
6.						
7.						
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type facilities					(6,899.44)
	Pharmacy Supplies per GL					179.60
	Manual Input from Related Party- Forum Drugs					67.00
9.	Total to line 9 Pharmacy		See Pg 16A	To Col 6		246.60
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					14.92
	Manual Input: Related Party - Prism					0.00
	Manual Input: Related Party FECII - I.V.					0.00
	Manual Input: Related Party FECII - Wound Care					(3.00)
	Oxygen, from reclass worksheet (Pg 4A)					0.00
13.	Col 6: Supplies Total			To Col 6		11.92
13.	Total Line 13, Column 8					11.92
14.	Total					258.52

Facility Name & ID Number Alden of Old Town West

0042077

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>100</u>)	247,921	247,921	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,093	6
7	Other Prepaid Expenses	927	927	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	6,486	16,597	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 255,334	\$ 270,538	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	29,795	36,948	15
16	Equipment, at Historical Cost	59,240	160,303	16
17	Accumulated Depreciation (book methods)	(59,536)	(392,078)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	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>	1,004,108	1,212,393	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,033,607	\$ 2,155,921	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,288,941	\$ 2,426,459	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 166,727	\$ 164,276	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		12,713	29
30	Accrued Salaries Payable	48,259	48,259	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,231	7,231	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
Other Current Liabilities(specify):				
36	<u>Accr Exp/Insur, Due State, Sales Tax, etc.</u>	21,266	21,266	36
37	<u>Due to Affiliates</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 244,674	\$ 274,010	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		312,572	39
40	Mortgage Payable		819,456	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Affiliates</u>			43
44	<u>S/holder loans, Others</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,132,028	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 244,674	\$ 1,406,038	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,044,267	\$ 1,020,421	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,288,941	\$ 2,426,459	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 934,850	1
2	Restatements (describe):		2
3	External audit adjustment made after 2008 cost report		3
4	was submitted. These have no effect on prior years report:		4
5	Fines, Penalties, & Unallowable Costs	(61,535)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 873,315	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	170,952	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)	\$ 170,952	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)	\$ 1,044,267	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden of Old Town West

0042077

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	\$ 1,321,296	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,321,296	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	6,486	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,486	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Pg 19A	307,634	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 307,634	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,635,429	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	192,776	31
32	Health Care	500,462	32
33	General Administration	261,603	33
B. Capital Expense			
34	Ownership	123,322	34
C. Ancillary Expense			
35	Special Cost Centers	313,584	35
36	Provider Participation Fee	72,730	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,464,477	40
41	Income before Income Taxes (line 30 minus line 40)**	170,952	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 170,952	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

<u>Description</u>	<u>Amount</u>
Misc Income - Jury Duty	\$ 17
Misc Income - Food Rebate	137
Misc Income - Wage Service Fee	
Gain on Sale of Assets	990
Day Training	306,490
Line 28 Total:	<u>\$ 307,634</u>

Facility Name & ID Number Alden of Old Town West

0042077

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	3,060	95,951	31.36	3
4	Licensed Practical Nurses	1,571	1,571	43,167	27.48	4
5	CNAs & Orderlies					5
6	CNA Trainees	596	596	5,062	8.49	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	130	2,586	19.89	13
14	Head Cook	4,155	4,217	49,620	11.77	14
15	Cook Helpers/Assistants	953	953	11,525	12.09	15
16	Dishwashers					16
17	Maintenance Workers	130	130	3,014	23.18	17
18	Housekeepers	1,497	1,497	14,573	9.73	18
19	Laundry					19
20	Administrator	559	559	15,533	27.79	20
21	Assistant Administrator	78	78	2,353	30.17	21
22	Other Administrative	165	180	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)	1,765	1,765	31,637	17.92	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	25,733	25,733	272,712	10.60	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Facility Manager	864	864	15,371	17.79	33
34	TOTAL (lines 1 - 33)	41,255	41,333	\$ 569,264 *	\$ 13.77	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	250/Month	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32/Month	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	411	22,214	11-3	44
45	Social Service Consultant	20	1,133	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	431	\$ 26,731		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Melissa Allison	Administrator	0	\$ 8,574	Workers' Compensation Insurance	\$ 14,722	IDPH License Fee	\$		
Dawn Schaeffer	Administrator	0	2,523	Unemployment Compensation Insurance	5,347	Advertising: Employee Recruitment	292		
Maryellen Schweitzer	Administrator	0	4,436	FICA Taxes	45,200	Health Care Worker Background Check			
Yvonne Harris	Assistant Admin	0	2,353	Employee Health Insurance	9,266	(Indicate # of checks performed 14)	140		
				Employee Meals	3,927	Patient Background Checks	2		
				Illinois Municipal Retirement Fund (IMRF)*		Surety Bond Fees	125		
				Life & Dental Insurance	503	Allscripts	196		
				Employee Relations & Misc Costs	440	IL Healthcare Assoc/Elim Non-Care Cost	618		
				Employee Drug Tests	304	Related Party-AMS/FECII/etc.	213		
				401K Match	664				
				Employee Vaccinations	381	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
(List each licensed administrator separately.)			\$ 17,886			\$ 1,604			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Related party - AMS	428	
(Attach a copy of any management service agreement)							Seminar Expense		
C. Professional Services							Leadership Training		595
Vendor/Payee	Type		Amount				Training Seminars		21
Alden Management Services	Consulting Fees		\$ 92,945				IHCA Conventions		914
Barry Greenburg	Legal Fees		87				Entertainment Expense		()
Ungaretti & Harris	Legal Fees		(99)				(agree to Sch. V, line 24, col. 8)		
Medifax/EDI	Billing Service (Reclassified)		42				TOTAL		\$ 1,958
First Advantage	Tax Consulting		137						
BDO Seidman	Accounting Fees		1,553						
Baker Tilly/Virchow Krause	Audit Fees		988						
TOTAL (agree to Schedule V, line 19, column 3)									
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 95,653						

* Attach copy of IMRF notifications

**See instructions.

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
1	Painting	12/08	\$ 3,848	3	\$	\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 3,848		\$	\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$	\$	\$							

Facility Name & ID Number Alden of Old Town West

0042077

Report Period Beginning:

1/1/09

Ending: 12/31/09

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. \$ 7,697 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. \$ 72,730
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. \$ 3,927 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.