

Facility Name & ID Number Alden Springs

0047191 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)		0	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6	16	ICF/DD 16 or Less	16	5,840	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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,286			5,286	13
14	TOTALS	5,286			5,286	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.51%

D. How many bed-hold days during this year were paid by the Department? 526 (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 10/13/06

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 Springs # 0047191 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	57,754	1,935		59,689	812	60,501	635	61,136		1
2	Food Purchase		49,238		49,238	(2,698)	46,540	(14,326)	32,214		2
3	Housekeeping	11,611	4,300		15,911		15,911	469	16,380		3
4	Laundry		3,679		3,679		3,679		3,679		4
5	Heat and Other Utilities			24,216	24,216		24,216	191	24,407		5
6	Maintenance	3,014		42,467	45,481		45,481	(895)	44,586		6
7	Other (specify):* Related party Benf.							756	756		7
8	TOTAL General Services	72,379	59,152	66,683	198,214	(1,886)	196,328	(13,170)	183,158		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	354,983	17,594	2,609	375,186	600	375,786	5,108	380,894		10
10a	Therapy					4,642	4,642	(3,660)	982		10a
11	Activities			23,517	23,517		23,517		23,517		11
12	Social Services	27,942			27,942		27,942		27,942		12
13	CNA Training	6,001			6,001		6,001		6,001		13
14	Program Transportation										14
15	Other (specify):* Related party Benf.							827	827		15
16	TOTAL Health Care and Programs	388,926	17,594	29,126	435,646	5,242	440,888	2,275	443,163		16
	C. General Administration										
17	Administrative	17,886			17,886		17,886	10,179	28,065		17
18	Directors Fees										18
19	Professional Services			86,545	86,545		86,545	(79,653)	6,892		19
20	Dues, Fees, Subscriptions & Promotions			5,772	5,772	(845)	4,927	(3,134)	1,793		20
21	Clerical & General Office Expenses	19,891	3,705	10,510	34,106		34,106	29,351	63,457		21
22	Employee Benefits & Payroll Taxes			59,246	59,246	1,286	60,532	(23)	60,509		22
23	Inservice Training & Education										23
24	Travel and Seminar			591	591	845	1,436	397	1,833		24
25	Other Admin. Staff Transportation			1,841	1,841		1,841	1,226	3,067		25
26	Insurance-Prop.Liab.Malpractice			17,416	17,416		17,416	1,783	19,199		26
27	Other (specify):* Related party Benf.			(585)	(585)		(585)	6,514	5,929		27
28	TOTAL General Administration	37,777	3,705	181,336	222,818	1,286	224,104	(33,360)	190,744		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	499,082	80,451	277,145	856,678	4,642	861,320	(44,255)	817,065		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 Springs

#0047191

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,232	3,232		3,232	62,096	65,328			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,385	6,385		6,385	90,707	97,092			32
33	Real Estate Taxes			50,364	50,364	(50,364)		50,909	50,909			33
34	Rent-Facility & Grounds			132,545	132,545	50,364	182,909	(182,909)				34
35	Rent-Equipment & Vehicles			3,965	3,965		3,965	4,097	8,062			35
36	Other (specify):*											36
37	TOTAL Ownership			196,491	196,491		196,491	24,900	221,391			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,929	4,641	10,570	(4,642)	5,928	(1,838)	4,090			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,542	62,542		62,542		62,542			42
43	Other (specify):* Day Training			281,905	281,905		281,905		281,905			43
44	TOTAL Special Cost Centers		5,929	349,088	355,017	(4,642)	350,375	(1,838)	348,537			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	499,082	86,380	822,724	1,408,186		1,408,186	(21,193)	1,386,993			45

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

Reclassifications on Pgs 3 & 4 - Column 5

Report Period Beginning: 1/1/2009

Report Period Ending: 12/31/2009

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2	22	(2,698.00)	Employee Meals
		2,698.00	Employee Meals
22	10	(1,412.00)	Uniforms
	1	600.00	Uniforms
	3	812.00	Uniforms
	4		Uniforms
	6		Uniforms
	11		Uniforms
	21		Uniforms
33	34	(50,364.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
		50,364.00	Rent - Real Estate Tax on associated landowner (Pg 6)
20	24	(845.00)	ILL Healthcare Ass. (IHCA Convention)
		845.00	ILL Healthcare Ass. (IHCA Convention)
<u>Others, if any:</u>			
39	10A	(4,642.00)	PT, OT, & ST CPT Therapy Costs
		4,642.00	PT, OT, & ST CPT Therapy Costs
Net		-	

Alden Springs

ID# 0047191
 Report Period Beginning: 1/1/09
 Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees on Utilities	\$ (95)	5	1
2	Intercompany Interest Not allowed (GL#7031)	(6,015)	32	2
3	Misc Income - Jury Duty	(23)	22	3
4	Misc. Income-Food Rebate	(67)	2	4
5	Miscellaneous Income - Garnishment Processing	(2)	21	5
6	Back out 30% (for 2009) of PAC fees	(265)	20	6
7	Elim. Landowner Bank Charges	(45)	19	7
8	Elim. Landowner Tax Penalty	(1,395)	32	8
9	Elim Deprec on Pg 12 < \$2,500 items	(42)	30	9
10	Elim Deprec on Pg 13 < \$2,500 items	(2,826)	30	10
11	Expense Pg 13 items< \$2,500 Curr Yr	1,155	6	11
12	Expense Pg 13 items< \$2,500	516	6	12
13	Expense Pg 12 items< \$2,500 (Related Party)	270	6	13
14	Adj for ABC cur. Yr purchase on Pg13	(13)	30	14
15	Misc.Depreciation adjustment	42	30	15
16	Elim PAC fees from Dues & Subscription	(13)	20	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	(8,818)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Springs

0047191

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	635	0	0	0	0	0	0	0	0	635	1
2	Food Purchase	(67)	0	0	(14,259)	0	0	0	0	0	0	0	(14,326)	2
3	Housekeeping	0	0	469	0	0	0	0	0	0	0	0	469	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(95)	0	286	0	0	0	0	0	0	0	0	191	5
6	Maintenance	1,941	0	(2,752)	0	0	0	(84)	0	0	0	0	(895)	6
7	Other (specify):*	0	0	618	138	0	0	0	0	0	0	0	756	7
8	TOTAL General Services	1,779	0	(744)	(14,121)	0	0	(84)	0	0	0	0	(13,170)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,979	65	64	0	0	0	0	0	0	5,108	10
10a	Therapy	0	0	0	0	0	(3,660)	0	0	0	0	0	(3,660)	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	827	0	0	0	0	0	0	0	0	827	15
16	TOTAL Health Care and Programs	0	0	5,806	65	64	(3,660)	0	0	0	0	0	2,275	16
	C. General Administration													
17	Administrative	0	0	10,179	0	0	0	0	0	0	0	0	10,179	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(45)	45	(79,653)	0	0	0	0	0	0	0	0	(79,653)	19
20	Fees, Subscriptions & Promotions	(3,442)	250	58	0	0	0	0	0	0	0	0	(3,134)	20
21	Clerical & General Office Expenses	(777)	0	26,685	3,199	244	0	0	0	0	0	0	29,351	21
22	Employee Benefits & Payroll Taxes	(23)	0	0	0	0	0	0	0	0	0	0	(23)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	397	0	0	0	0	0	0	0	0	397	24
25	Other Admin. Staff Transportation	0	0	1,226	0	0	0	0	0	0	0	0	1,226	25
26	Insurance-Prop.Liab.Malpractice	0	1,766	17	0	0	0	0	0	0	0	0	1,783	26
27	Other (specify):*	585	0	5,513	397	19	0	0	0	0	0	0	6,514	27
28	TOTAL General Administration	(3,702)	2,061	(35,578)	3,596	263	0	0	0	0	0	0	(33,360)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,923)	2,061	(30,516)	(10,460)	327	(3,660)	(84)	0	0	0	0	(44,255)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Springs

0047191

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	(2,839)	60,705	2,864	0	1,366	0	0	0	0	0	0	62,096	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,516)	91,334	6,877	0	12	0	0	0	0	0	0	90,707	32
33	Real Estate Taxes	0	50,364	543	0	2	0	0	0	0	0	0	50,909	33
34	Rent-Facility & Grounds	0	(182,909)	0	0	0	0	0	0	0	0	0	(182,909)	34
35	Rent-Equipment & Vehicles	0	0	4,097	0	0	0	0	0	0	0	0	4,097	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,355)	19,494	14,381	0	1,380	0	0	0	0	0	0	24,900	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	(1,903)	65	0	0	0	0	0	0	(1,838)	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	(1,903)	65	0	0	0	0	0	0	(1,838)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(12,278)	21,555	(16,135)	(12,363)	1,772	(3,660)	(84)	0	0	0	0	(21,193)	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 Rent Income	\$ 182,909	Alden Trails II, LLC		\$	(182,909)	1
2	V	19 Bank Charges		Alden Trails II, LLC		45	45	2
3	V	20 Dues & Subscriptions		Alden Trails II, LLC		250	250	3
4	V	33 Real Estate Tax Expense		Alden Trails II, LLC		50,364	50,364	4
5	V	26 General Insurance Expense		Alden Trails II, LLC		1,766	1,766	5
6	V	32 Interest - Harris		Alden Trails II, LLC		89,939	89,939	6
7	V	30 Depreciation		Alden Trails II, LLC		60,705	60,705	7
8	V	32 Tax Penalty		Alden Trails II, LLC		1,395	1,395	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 182,909			\$ 204,464	\$ * 21,555	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.		\$ 286	\$	286	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		397		397	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,226		1,226	17
18	V	26 Insurance		Alden Management Services, Inc.		17		17	18
19	V	20 Dues/Subscriptions		Alden Management Services, Inc.		58		58	19
20	V	30 Depreciation		Alden Management Services, Inc.		2,864		2,864	20
21	V	33 Real Estate Tax		Alden Management Services, Inc.		543		543	21
22	V	35 Rent-Equip/Vehic		Alden Management Services, Inc.		4,097		4,097	22
23	V	32 Interest		Alden Management Services, Inc.		6,877		6,877	23
24	V	1 Dietary Salary		Alden Management Services, Inc.		635		635	24
25	V	3 Housekeeping Salary		Alden Management Services, Inc.		469		469	25
26	V	7 Employee Benef-Gen'l Servs		Alden Management Services, Inc.		618		618	26
27	V	10 Nurs/Med Rec Salary		Alden Management Services, Inc.		4,979		4,979	27
28	V	15 Employee Benef-Health Care		Alden Management Services, Inc.		827		827	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		10,179		10,179	29
30	V	27 Employee Benef-Administrative		Alden Management Services, Inc.		5,513		5,513	30
31	V	19 Professional Fees	84,062	Alden Management Services, Inc.		4,409		(79,653)	31
32	V	21 Gen'l & Admin		Alden Management Services, Inc.		26,685		26,685	32
33	V	6 Repair & Mainten.	6,570	Alden Management Services, Inc.		3,818		(2,752)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 90,632			\$ 74,497	\$ *	(16,135)	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	\$ 19,551	Prism Health Care Services, Inc.		\$ 5,292	\$ (14,259)
16	V	10 Equipment Rental	360	Prism Health Care Services, Inc.		425	65
17	V	39 Supplies	4,843	Prism Health Care Services, Inc.		2,940	(1,903)
18	V	21 Salary G & A		Prism Health Care Services, Inc.		2,076	2,076
19	V	27 Employee Benefits		Prism Health Care Services, Inc.		397	397
20	V	7 Employee Benefits		Prism Health Care Services, Inc.		138	138
21	V	21 G & A		Prism Health Care Services, Inc.		1,123	1,123
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		\$ 24,754			\$ 12,391	\$ * (12,363)

* 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	\$ 505	Forum Extended Care Services II, Inc.		\$ 693	\$ 188	15
16	V	39 IV		Forum Extended Care Services II, Inc.				16
17	V	39 Wound Care	580	Forum Extended Care Services II, Inc.		457	(123)	17
18	V	10 House Stock	1,671	Forum Extended Care Services II, Inc.		1,516	(155)	18
19	V	10 Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		603	219	19
20	V	27 Employee Vaccinations		Forum Extended Care Services II, Inc.				20
21	V	27 Employee Benefit: G & A		Forum Extended Care Services II, Inc.		19	19	21
22	V	21 Salary: G & A		Forum Extended Care Services II, Inc.		156	156	22
23	V	21 General & Administrative		Forum Extended Care Services II, Inc.		88	88	23
24	V	32 Interest		Forum Extended Care Services II, Inc.		12	12	24
25	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		2	2	25
26	V	30 Depreciation		Forum Extended Care Services II, Inc.		1,366	1,366	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 3,140			\$ 4,912	\$ * 1,772	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10a Therapy	\$ 4,641	Community Physical Therapy & Associates, Ltd.		\$ 981	\$ (3,660)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 4,641			\$ 981	\$ * (3,660)

* 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	\$ 6,384	Alden Bennett Construction Company, Inc.	0.00%	\$ 6,300	\$	(84)	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		\$ 6,384			\$ 6,300	\$ *	(84)	39

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

Facility Name & ID Number Alden Springs

Provider No. 0047191

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 Springs

0047191

Report Period Beginning:

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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	184,200	0.172	0.43	Salary	\$ 800	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,343	0.172	0.43	Salary	297	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,349	0.172	0.43	Salary	171	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	\$ 1,268		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 Springs

0047191

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	1,221,923	31	\$ 66,061	\$ 5,812	\$ 286	1	
2	24	Trav & Seminar	Patient Days	1,221,923	31	91,753	5,812	397	2	
3	25	Other Admin Travel	Patient Days	1,221,923	31	283,487	5,812	1,226	3	
4	26	Insurance	Patient Days	1,221,923	31	3,990	5,812	17	4	
5	20	Dues & Subscriptions	Patient Days	1,221,923	31	13,454	5,812	58	5	
6	30	Depreciation	No of Providers/usage	31	31	102,169	1	2,864	6	
7	33	Real Estate Tax	Patient Days/ysage	1,221,923	31	139,876	5,812	543	7	
8	35	Rent-Equip & Vehicle	Patient Days	1,221,923	31	947,116	5,812	4,097	8	
9	32	Interest	Patient Days/usage	1,221,923	31	1,339,694	5,812	6,877	9	
10	1	Dietary Salary	Patient Days	1,221,923	31	146,892	146,892	5,812	635	10
11	3	Housekeeping Salary	Patient Days	1,221,923	31	108,487	108,487	5,812	469	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,221,923	31	142,881	5,812	618	12	
13	10	Nurs & Med Records Salary	Patient Days	1,221,923	31	1,259,741	1,259,741	5,812	4,979	13
14	15	Employee Benefits -Health Care	Patient Days	1,221,923	31	191,270	5,812	827	14	
15	17	Administrative Salary	Patient Days/usage	1,221,923	31	2,477,865	2,477,865	5,812	10,179	15
16	27	Employee Benefits - Admin	Patient Days	1,221,923	31	1,274,479	5,812	5,513	16	
17	19	Professional fees	Patient Days	1,221,923	31	1,019,103	624,209	5,812	4,409	17
18	21	Gen'I & Admin	Patient Days	1,221,923	31	6,168,666	5,291,904	5,812	26,685	18
19	6	Repair & Maint.	Patient Days	1,221,923	31	882,577	685,666	5,812	3,818	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 16,659,561	\$ 10,594,764	\$ 74,497	25	

Facility Name & ID Number

Alden Springs

0047191

Report Period Beginning:

1/1/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										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	Harris (GI 2512/7044)		x	Mortgage	\$10,752.46	12/1/06	\$ 1,781,000	\$ 1,670,328	11/01/2011	5.2500	\$ 89,939	1								
2												2								
3												3								
4	Amortization-Fin/Refin Fee		x									4								
5	Insurance Interest		x	Medical Malpractice							291	5								
Working Capital																				
6	Related party-AMS		x								6,877	6								
7	Related party-FECH		x								12	7								
8												8								
9	TOTAL Facility Related				\$10,752.46		\$ 1,781,000	\$ 1,670,328			\$ 97,119	9								
B. Non-Facility Related*																				
10	Interest Inc (Corp)		X								(27)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (27)	14								
15	TOTALS (line 9+line14)						\$ 1,781,000	\$ 1,670,328			\$ 97,092	15								

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

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

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

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and			
1. Real Estate Tax accrual used on 2008 report.				\$	3,600
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	26,564
3. Under or (over) accrual (line 2 minus line 1).				\$	22,964
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	27,400
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	50,364
			Plus: Related Party Taxes (2) - See Pg 10A		545
Real Estate Tax History:				\$	50,909
Real Estate Tax Bill for Calendar Year:	2004	N/A	8		
	2005	4,146	9		
	2006	3,686	10		
	2007	3,525	11		
	2008	26,564	12		
The current year accrual is based on an estimated 3% increase of the prior year tax.					
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2008	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

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Ending:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,150 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories One

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building</u>	<u>22,035</u>		<u>\$ 398,630</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>22,035</u>		<u>\$ 398,630</u>	<u>3</u>

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

1/1/09

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		2006	\$ 1,583,599	\$ 39,590	40	\$ 39,590	\$	\$ 128,667
5			2006	69,510	1,738	40	1,738		5,648
6			2006	20,156	504	40	504		1,848
7									
8	Related Party-Forum		1978	14,056		25			14,056
	Improvement Type**								
9	Wiring		2006	840	42	20	42		137
10									
11	Drywall Carpentry		2007	18,677	1,245	15	1,245		3,320
12	Plumb, Floor Prep, Fencing-ABC Renovation		2007	23,127	2,313	10	2,313		6,939
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

1/1/09

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,729,966	\$ 45,432		\$ 45,432	\$	\$ 160,615	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)		\$ 1,800,745	\$ 48,046		\$ 48,046	\$	\$ 220,557	34

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

Facility Name & ID Number Alden Springs

0047191

Report Period Beginning:

1/1/09

Ending:

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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	\$ 157,912	\$ 15,817	\$ 15,817	\$		\$ 54,191	71
72	Current Year Purchases	12,735	1,015	1,015			1,015	72
73	Fully Depreciated Assets	71,132	450	450			71,132	73
74								74
75	TOTALS	\$ 241,779	\$ 17,282	\$ 17,282	\$		\$ 126,338	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Related Party - AMS	Various	98-'02	4,415					4,415	79
80	TOTALS			\$ 4,415	\$	\$	\$		\$ 4,415	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,445,569	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,328	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,328	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)	\$ 351,310	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: \$ 4,763 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>213.17</u>	\$ <u>2,558</u>	17
18					18
19			<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>213.17</u>	\$ <u>2,558</u>	21

10. Effective dates of current rental agreement:

Beginning 1/1/2007

Ending 11/1/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/> 7	IN OTHER FACILITY <input type="checkbox"/> 7
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <input type="checkbox"/> 73
		HOURS PER CNA <input type="checkbox"/> 28	

Skilled nursing on site

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)		1,683		1,683
4	Clinical Wages (b)	238	4,080		4,318
5	In-House Trainer Wages (c)			249	249
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 238	\$ 5,763	\$ 249	\$ 6,250
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,001			

C. CONTRACTUAL INCOME

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

\$ Not Applicable

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	7

- (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				693		693	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>						3,397		3,397	13
14	TOTAL			\$		\$	4,090		\$ 4,090	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, & ST
 Col 6: Supplies

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	
2. ST	39-3	To Col 5	
3.			
4. PT	39-3	To Col 5	
5.			
6.			
7.			
8.			
Pharmacy Supplies per GL			505.40
Manual Input from Related Party- Forum Drugs			188.00
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	693.40
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	0.00
Other			5,423.20
Manual Input: Related Party - Prism			(1,903.00)
Manual Input: Related Party FECII - I.V.			
Manual Input: Related Party FECII - Wound care Oxygen, from reclass worksheet			(123.00)
13. Col 6: Supplies Total		To Col 6	3,397.20
13. Total Line 13, Column 8			3,397.20
14. Total			4,090.60

Facility Name & ID Number Alden Springs

0047191

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>(100)</u>)	250,235	250,235	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		1,655	6
7	Other Prepaid Expenses	4,602	4,602	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	8,216	8,216	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 263,053	\$ 264,708	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		398,630	13
14	Buildings, at Historical Cost		1,674,106	14
15	Leasehold Improvements, at Historical Cost	18,677	18,677	15
16	Equipment, at Historical Cost	19,609	204,758	16
17	Accumulated Depreciation (book methods)	(7,871)	(204,425)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 30,415	\$ 2,091,746	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 293,468	\$ 2,356,454	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 140,852	\$ 224,967	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,428	1,428	28
29	Short-Term Notes Payable		41,117	29
30	Accrued Salaries Payable	31,607	31,607	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,810	5,810	31
32	Accrued Real Estate Taxes(Sch.IX-B)		27,400	32
33	Accrued Interest Payable		7,551	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>	17,502	17,502	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 197,199	\$ 357,382	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,629,211	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Affiliates</u>	131,459	33,624	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 131,459	\$ 1,662,835	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 328,658	\$ 2,020,217	46
47	TOTAL EQUITY(page 18, line 24)	\$ (35,191)	\$ 336,237	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 293,468	\$ 2,356,454	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (190,023)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2006 cost report	80,115	3
4	was submitted. These have no effect on prior years report		4
5	Bad debt, Medicare revenues (non allowables)		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (109,908)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	74,718	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)	\$ 74,718	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)	\$ (35,191)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Springs

0047191

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	\$ 1,192,665	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,192,665	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	8,216	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)	\$ 8,216	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	26	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Page 19A</u>	281,997	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 281,997	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,482,904	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	198,214	31
32	Health Care	435,646	32
33	General Administration	222,818	33
B. Capital Expense			
34	Ownership	196,491	34
C. Ancillary Expense			
35	Special Cost Centers	292,475	35
36	Provider Participation Fee	62,542	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,408,186	40
41	Income before Income Taxes (line 30 minus line 40)**	74,718	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 74,718	43

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

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Alden Springs # 0047191 Report Period Beginning: 1/1/09 Ending: 12/31/09

Details of Page 19, Line 28

Miscellaneous Income-Jury Duty	23.00
Miscellaneous Income-Food Vendor Rebate	67.00
Miscellaneous Income-Garnishment	2.00
Day Training Income	281,905.00
	281,997.00

Facility Name & ID Number Alden Springs

0047191

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	1,091	1,091	32,663	29.94	3
4	Licensed Practical Nurses	2,944	3,032	78,999	26.06	4
5	CNAs & Orderlies					5
6	CNA Trainees	706	706	6,001	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	130	2,586	19.89	13
14	Head Cook	4,309	4,309	51,986	12.06	14
15	Cook Helpers/Assistants	268	268	3,181	11.87	15
16	Dishwashers					16
17	Maintenance Workers	130	130	3,014	23.18	17
18	Housekeepers	1,217	1,217	11,612	9.54	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)	1,272	1,272	27,942	21.97	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	20,618	22,126	243,321	11.00	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Facility Manager	768	768	13,731	17.88	33
34	TOTAL (lines 1 - 33)	34,254	35,866	\$ 499,082 *	\$ 13.92	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/Monthly	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	32/Monthly	384		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	418	22,348	11-3	44
45	Social Service Consultant	15	1,001		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	433	\$ 26,733		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 Springs

0047191

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 Assn. \$ 883
- (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. \$ 6,815 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. \$ 62,542
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. \$ 2,698 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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.