

		FOR BHF USE					

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**2010  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2010)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0042077</u></p> <p><b>Facility Name:</b> <u>Alden of Old Town West</u></p> <p><b>Address:</b> <u>118 South Bloomingdale Road</u> <u>Bloomingdale</u> <u>60108</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>DuPage</u></p> <p><b>Telephone Number:</b> <u>(630)671-1660</u> <b>Fax #</b> <u>(630)671-0457</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>05/19/98</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input checked="" type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven M. Kroll</u> <b>Telephone Number:</b> <u>(773) 286-3883</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/10</u> to <u>12/31/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Joan Carl</u> (Title) <u>Vice-President</u></td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Joan Carl</u> (Title) <u>Vice-President</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Joan Carl</u> (Title) <u>Vice-President</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Alden of Old Town West

# 0042077 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	5,613			5,613	13
14	TOTALS	5,613			5,613	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.11%

D. How many bed-hold days during this year were paid by the Department? 81 (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

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Alden of Old Town West # 0042077 Report Period Beginning: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	57,368	5,020	1,103	63,491	242	63,733	131	63,864		1
2	Food Purchase		46,147		46,147	(8,205)	37,942	68	38,010		2
3	Housekeeping	18,126	7,193		25,319		25,319	687	26,006		3
4	Laundry		5,057		5,057		5,057		5,057		4
5	Heat and Other Utilities			17,443	17,443	246	17,689	286	17,975		5
6	Maintenance	3,093		46,275	49,368	123	49,491	4,716	54,207		6
7	Other (specify):* <b>Related Party</b>							717	717		7
8	<b>TOTAL General Services</b>	78,587	63,417	64,821	206,825	(7,594)	199,231	6,605	205,836		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	431,690	27,827	1,365	460,882	5,028	465,910	6,034	471,944		10
10a	Therapy		441		441	8,008	8,449	(5,687)	2,762		10a
11	Activities		58	22,333	22,391		22,391		22,391		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Related Party</b>							870	870		15
16	<b>TOTAL Health Care and Programs</b>	431,690	28,326	26,698	486,714	13,036	499,750	1,217	500,967		16
	<b>C. General Administration</b>										
17	Administrative	15,969			15,969		15,969	11,479	27,448		17
18	Directors Fees										18
19	Professional Services			100,458	100,458	(3,460)	96,998	(86,137)	10,861		19
20	Dues, Fees, Subscriptions & Promotions			11,054	11,054		11,054	(9,370)	1,684		20
21	Clerical & General Office Expenses	39,338	2,697	12,257	54,292	(327)	53,965	29,765	83,730		21
22	Employee Benefits & Payroll Taxes			88,392	88,392	6,353	94,745	(544)	94,201		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,485	2,485		2,485	(194)	2,291		24
25	Other Admin. Staff Transportation			3,787	3,787		3,787	1,580	5,367		25
26	Insurance-Prop.Liab.Malpractice			16,799	16,799		16,799	1,073	17,872		26
27	Other (specify):* <b>Bad Debt,Related Party</b>			269	269		269	5,755	6,024		27
28	<b>TOTAL General Administration</b>	55,307	2,697	235,501	293,505	2,566	296,071	(46,593)	249,478		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	565,584	94,440	327,020	987,044	8,008	995,052	(38,771)	956,281		29

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

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

Facility Name &amp; ID Number

Alden of Old Town West

#0042077

Report Period Beginning:

1/1/10

Ending:

12/31/10

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			4,021	4,021		4,021	31,772	35,793			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,747	21,747		21,747	52,325	74,072			32
33	Real Estate Taxes							15,293	15,293			33
34	Rent-Facility & Grounds			94,395	94,395		94,395	(94,395)				34
35	Rent-Equipment & Vehicles			3,972	3,972		3,972	4,054	8,026			35
36	Other (specify):*							6,636	6,636			36
37	<b>TOTAL Ownership</b>			124,135	124,135		124,135	15,685	139,820			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,242	8,008	9,250	(8,008)	1,242	(606)	636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,496	72,496		72,496		72,496			42
43	Other (specify):* <b>Day Training DDs</b>			284,396	284,396		284,396		284,396			43
44	<b>TOTAL Special Cost Centers</b>		1,242	364,900	366,142	(8,008)	358,134	(606)	357,528			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	565,584	95,682	816,055	1,477,321		1,477,321	(23,692)	1,453,629			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: 004-2007

1/1/2010  
 12/31/2010

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<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(8,205.00)	Employee Meals
	22	8,205.00	Employee Meals
22		(1,852.00)	Uniforms
	1	242.00	Uniforms
	3		Uniforms
	4		Uniforms
	6		Uniforms
	10	1,610.00	Uniforms
	11		Uniforms
	21		Uniforms
10			Oxygen - to appropriate cost center
	39		Oxygen - to appropriate cost center
21		(246.00)	Vendor Settlements
	5	246.00	Vendor Settlements
21		(123.00)	Vendor Settlements
	6	123.00	Vendor Settlements
<u>Others, if any:</u>			
19		(3,418.00)	Reclass Clinical Coordinators to Ln 10
	10	3,418.00	Reclass Clinical Coordinators to Ln 10
39		(8,008.00)	PT, OT, & ST CPT Therapy Costs
	10a	8,008.00	PT, OT, & ST CPT Therapy Costs
19		(42.00)	MedCom Software Services
	21	42.00	MedCom Software Services
Net		-	



Facility Name & ID Number Alden of Old Town West

# 0042077

Report Period Beginning:

1/1/10

Ending:

12/31/10

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(178)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(157)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(268)	27		24
25	Fund Raising, Advertising and Promotional	(1,987)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,603)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(16,009)	Various	34
35	Other- Attach Schedule	(5,080)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (21,089)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (23,692)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Alden of Old Town West

ID# 0042077

Report Period Beginning: 1/1/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees on Utilities	\$ (27)	5	1
2	Intercompany Interest	(7,350)	32	2
3	Misc. Income - Wage Service Fee	(14)	22	3
4	Misc. Income - Workers Comp Refund	(29)	22	4
5	Misc. Income - Other	(501)	22	5
6	Back out 30% of PAC fees from IHCA	(265)	20	6
7	Deming Training Cost	(600)	24	7
8	Elim Deprec on Pg 13 < \$2,500 items	(1,863)	30	8
9	Expense Pg 13 items < \$2,500 curr yr	5,281	6	9
10	Expense Pg 13 items < \$2,500	320	6	10
11	Elim Deprec on Pg 12 < \$2,500 items	(582)	30	11
12	Expense Pg 12 items < \$2,500	1,236	6	12
13	Adj depr exp page 13	(686)	30	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,080)		49

## STATE OF ILLINOIS

Summary A

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

# 0042077

Report Period Beginning:

1/1/10

Ending:

12/31/10

## 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	510	(379)	0	0	0	0	0	0	0	131	1
2	Food Purchase	0	0	0	68	0	0	0	0	0	0	0	68	2
3	Housekeeping	0	0	687	0	0	0	0	0	0	0	0	687	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(27)	0	313	0	0	0	0	0	0	0	0	286	5
6	Maintenance	6,659	621	(2,435)	0	0	0	(129)	0	0	0	0	4,716	6
7	Other (specify):*	0	0	696	21	0	0	0	0	0	0	0	717	7
8	<b>TOTAL General Services</b>	<b>6,632</b>	<b>621</b>	<b>(229)</b>	<b>(290)</b>	<b>0</b>	<b>0</b>	<b>(129)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6,605</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	5,833	27	174	0	0	0	0	0	0	6,034	10
10a	Therapy	0	0	0	0	0	(5,687)	0	0	0	0	0	(5,687)	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	870	0	0	0	0	0	0	0	0	870	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>6,703</b>	<b>27</b>	<b>174</b>	<b>(5,687)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,217</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	11,479	0	0	0	0	0	0	0	0	11,479	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,110	(88,247)	0	0	0	0	0	0	0	0	(86,137)	19
20	Fees, Subscriptions & Promotions	(2,409)	150	(7,111)	0	0	0	0	0	0	0	0	(9,370)	20
21	Clerical & General Office Expenses	0	0	29,225	380	160	0	0	0	0	0	0	29,765	21
22	Employee Benefits & Payroll Taxes	(544)	0	0	0	0	0	0	0	0	0	0	(544)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(600)	0	406	0	0	0	0	0	0	0	0	(194)	24
25	Other Admin. Staff Transportation	0	0	1,580	0	0	0	0	0	0	0	0	1,580	25
26	Insurance-Prop.Liab.Malpractice	0	1,056	17	0	0	0	0	0	0	0	0	1,073	26
27	Other (specify):*	(268)	0	6,002	50	(29)	0	0	0	0	0	0	5,755	27
28	<b>TOTAL General Administration</b>	<b>(3,821)</b>	<b>3,316</b>	<b>(46,649)</b>	<b>430</b>	<b>131</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(46,593)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>2,811</b>	<b>3,937</b>	<b>(40,175)</b>	<b>167</b>	<b>305</b>	<b>(5,687)</b>	<b>(129)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(38,771)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden of Old Town West

# 0042077

Report Period Beginning:

1/1/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(3,131)	33,354	1,549	0	0	0	0	0	0	0	0	31,772	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,363)	53,358	6,325	0	5	0	0	0	0	0	0	52,325	32
33	Real Estate Taxes	0	14,769	522	0	2	0	0	0	0	0	0	15,293	33
34	Rent-Facility & Grounds	0	(94,395)	0	0	0	0	0	0	0	0	0	(94,395)	34
35	Rent-Equipment & Vehicles	0	0	4,054	0	0	0	0	0	0	0	0	4,054	35
36	Other (specify):*	0	6,636	0	0	0	0	0	0	0	0	0	6,636	36
37	<b>TOTAL Ownership</b>	<b>(10,494)</b>	<b>13,722</b>	<b>12,450</b>	<b>0</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>15,685</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(524)	(82)	0	0	0	0	0	0	(606)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(524)</b>	<b>(82)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(606)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(7,683)	17,659	(27,725)	(357)	230	(5,687)	(129)	0	0	0	0	(23,692)	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	\$ 94,395	Alden of Bloomingdale Limited Partnership	0.00%	\$	\$ (94,395)	1
2	V	32 Interest Income	14,197	Alden of Bloomingdale Limited Partnership			(14,197)	2
3	V	32 Interest Income - RR	42	Alden of Bloomingdale Limited Partnership			(42)	3
4	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		2,110	2,110	4
5	V	6 R & M-Replacement Reserve		Alden of Bloomingdale Limited Partnership		621	621	5
6	V	20 Dues & Subscriptions/Licenses & Inspections		Alden of Bloomingdale Limited Partnership		150	150	6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		14,769	14,769	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,056	1,056	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		6,636	6,636	9
10	V	32 Interest - Other		Alden of Bloomingdale Limited Partnership		45,293	45,293	10
11	V	32 Interest - IOD		Alden of Bloomingdale Limited Partnership		21,475	21,475	11
12	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		33,354	33,354	12
13	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		829	829	13
14	Total		\$ 108,634			\$ 126,293	\$ * 17,659	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%	\$ 313	\$	313	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		406		406	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,580		1,580	17
18	V	26 Insurance		Alden Management Services, Inc.		17		17	18
19	V	20 Dues & Subscriptions	7,248	Alden Management Services, Inc.		137		(7,111)	19
20	V	30 Depreciation		Alden Management Services, Inc.		1,549		1,549	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		522		522	21
22	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		4,054		4,054	22
23	V	32 Interest		Alden Management Services, Inc.		6,325		6,325	23
24	V	1 Dietary		Alden Management Services, Inc.		510		510	24
25	V	3 Houskeeping		Alden Management Services, Inc.		687		687	25
26	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		696		696	26
27	V	10 Nursing & Medical Records Salaries		Alden Management Services, Inc.		5,833		5,833	27
28	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		870		870	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		11,479		11,479	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		6,002		6,002	30
31	V	19 Professional Fees	93,667	Alden Management Services, Inc.		5,420		(88,247)	31
32	V	21 General & Administrative		Alden Management Services, Inc.		29,225		29,225	32
33	V	6 Repairs & Maintenance	7,000	Alden Management Services, Inc.		4,565		(2,435)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 107,915			\$ 80,190	\$ *	(27,725)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary Consultant	\$ 1,100	Prism Health Care Services, Inc.	0.00%	\$ 156	\$ (944)	15
16	V	1 Dietary Salary		Prism Health Care Services, Inc.		565	565	16
17	V	2 Tube Feeding	39	Prism Health Care Services, Inc.		107	68	17
18	V	10 Equipment Rental	361	Prism Health Care Services, Inc.		388	27	18
19	V	39 Ancillary Supplies	1,033	Prism Health Care Services, Inc.		509	(524)	19
20	V	21 Gen'l & Admin Salary		Prism Health Care Services, Inc.		267	267	20
21	V	27 Employee Benefits		Prism Health Care Services, Inc.		50	50	21
22	V	7 Employee Benefits		Prism Health Care Services, Inc.		21	21	22
23	V	21 General & Administrative		Prism Health Care Services, Inc.		113	113	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		\$ 2,533			\$ 2,176	\$ * (357)	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	\$ (60)	Forum Extended Care Services II, Inc.	0.00%	\$ (85)	\$ (25)	15
16	V	39 Wound Care	270	Forum Extended Care Services II, Inc.		213	(57)	16
17	V	10 House Stock	1,109	Forum Extended Care Services II, Inc.		1,019	(90)	17
18	V	10 Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		648	264	18
19	V	27 Employee Vaccination	201	Forum Extended Care Services II, Inc.		160	(41)	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.		98	98	21
22	V	21 Gen'l & Admin.		Forum Extended Care Services II, Inc.		62	62	22
23	V	32 Interest		Forum Extended Care Services II, Inc.		5	5	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.				25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,904			\$ 2,134	\$ * 230	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	\$ 8,008	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 2,321	\$ (5,687)
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		\$ 8,008			\$ 2,321	\$ * (5,687)

\* 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	\$ 10,567	Alden Bennett Construction Company, Inc.	0.00%	\$ 10,438	\$ (129)
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		\$ 10,567			\$ 10,438	\$ * (129)

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

Alden of Old Town West

Alden of Old Town West

Provider No. 0042077

Report Period Beginning:

1/1/10

Ending: 12/31/10

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 Gardens of Bloomingdale, Inc.	Bloomingdale	Supportive Living Facility
Alden of Old Town East, Inc.	Bloomingdale	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.	Bloomingdale	Community Physical Therapy & Associates, Ltd.	Addison	Therapy Provider
Alden Village Health Facility for Children and Young Adults, Inc.	Bloomingdale	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.	Bloomingdale			
Alden - Town Manor Rehabilitation and Health Care Center, Inc.	Cicero			
Alden Trails, Inc.	Bloomingdale			
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.	Bloomingdale			
Alden Village North, Inc.	Chicago			
Alden Estates of Skokie, Inc.	Skokie			
Alden Estates of Countryside, Inc.	Jefferson, WI			

Facility Name &amp; ID Number

Alden of Old Town West

# 0042077

Report Period Beginning:

1/1/10

Ending:

12/31/10

## 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	184,191	0.176	0.00	Salary	\$ 809	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,340	0.176	0.00	Salary	300	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,347	0.176	0.00	Salary	173	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	\$ 1,282		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:

1/1/10

Ending: 12/31/10

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*	33	\$ 71,628	\$	5,613	\$ 313	1
2	24	Travel/Seminar	patient days*	33	92,957		5,613	406	2
3	25	Other Admin Travel	patient days*	33	361,409		5,613	1,580	3
4	26	Insurance	patient days*	33	3,773		5,613	17	4
5	20	Dues/Subscriptions	patient days*	33	31,234		5,613	137	5
6	30	Depreciation	no. of providers	33	64,513		1	1,549	6
7	33	Real Estate Tax	patient days*	33	135,456		5,613	522	7
8	35	Rent-Equip/Vehicle	patient days*	33	927,091		5,613	4,054	8
9	32	Interest	patient days*	33	1,179,658		5,613	6,325	9
10	1	Dietary Salary	patient days*	33	116,597	116,597	5,613	510	10
11	3	Housekeeping Salary	patient days*	33	157,195	157,195	5,613	687	11
12	7	Employee Benef-Gen'l Servs	patient days*	33	159,672		5,613	696	12
13	10	Nurs/Med Rec Salary	patient days*	33	1,369,902	1,369,902	5,613	5,833	13
14	15	Employee Benef-Health Care	patient days*	33	199,071		5,613	870	14
15	17	Administrative Salary	patient days*	33	2,862,453	2,862,453	5,613	11,479	15
16	27	Employee Benef-Administrative	patient days*	33	1,372,540		5,613	6,002	16
17	19	Professional Fees	patient days*	33	1,239,391	672,679	5,613	5,420	17
18	21	Gen'l & Admin	patient days*	33	6,683,349	5,909,984	5,613	29,225	18
19	6	Repair & Mainten.	patient days*	33	1,043,713	824,986	5,613	4,565	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 18,071,602	\$ 11,913,796		\$ 80,190	25

Facility Name & ID Number

Alden of Old Town West

# 0042077

Report Period Beginning:

1/1/10

Ending:

12/31/10

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Cambridge		x	Operating Loss Loan	\$2,122.33	6/02	\$ 339,267	\$ 312,572	09/2037	6.8600	\$ 21,475	1							
2	Cambridge		x	Mortgage	\$4,506.29	9/03	873,700	819,456	08/2043	5.5000	45,293	2							
3												3							
4	Amortization-Fin/Refin Fee		x	Financing							829	4							
5	Insurance Interest		x	Medical Malpractice							200	5							
<b>Working Capital</b>																			
6	Related party-AMS		x	working capital							6,325	6							
7	Related party-FECH		x	working capital							5	7							
8												8							
9	TOTAL Facility Related				\$6,628.62		\$ 1,212,967	\$ 1,132,028			\$ 74,127	9							
<b>B. Non-Facility Related*</b>																			
10	Interest		x	Replacement Reserve							(42)	10							
11	Interest Inc (Corp)		x	Patient Interest							(13)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (55)	14							
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,132,028			\$ 74,072	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,636 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:

1/1/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	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	<b>TOTALS</b>	<b>18,000</b>		<b>\$ 150,868</b>	<b>3</b>

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		269,397	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sprinkler system		1999	1,510	101	15	101		1,201	9
10	ABC-counter tops		2004	8,102	810	10	810		6,278	10
11	ABC-Installed Dining Room Flooring		2005	5,421	361	15	361		1,956	11
12	ABC-Kitchen Repairs		2005	6,146	410	15	410		2,254	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

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 956,040	\$ 25,053		\$ 25,053	\$	\$ 281,086	1
2	Forum Prof Ctr: Remodeling	1979	12,778		20			12,778	2
3	Forum Prof Ctr: Build Improv - multiple	1980	24,885		15			24,885	3
4	Forum Prof Ctr: Tennant Improv	1986	785		13			785	4
5	Forum Prof Ctr: AMS remodel	1990	5,337		10			5,337	5
6	Forum Prof Ctr: Roof	1994	2,815	175	16	175		2,815	6
7	Forum Prof Ctr: Build Improv-multiple	1995	993	62	16	62		927	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,568	112	10	112		1,517	8
9	Forum Prof Ctr: Remodel/electrical	2001	611	33	7	33		544	9
10	Forum Prof Ctr: bathroom remodel	2002	540	50	5	50		452	10
11	Forum Prof Ctr: remodel suites/etc.	2003	694	70	9	70		555	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,138	104	7	104		1,762	12
13	Forum Prof Ctr: Suite renovation	2005	432	62	10	62		432	13
14	Forum Prof Ctr: Superior installations, etc.	2006	85	12	4	12		85	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	415	65	7	65		215	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	346	60	7	60		142	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	715	68	7	68		82	17
18	Forum Prof Ctr: Building Renovations	2010	1,161	330	7	330		330	18
19	Alden Mgt Servs: Remodel suites	1993	7,174	23	7	23		7,163	19
20	Alden Mgt Servs: Remodel suites	2002	299		7			299	20
21	Alden Mgt Servs: Remodel suites	2003	6,486	161	7	161		6,474	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,026,297	\$ 26,441		\$ 26,441	\$	\$ 348,664	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	\$ 99,607	\$ 7,745	\$ 7,745	\$		\$ 75,758	71
72	Current Year Purchases	38,619	1,584	1,584			1,584	72
73	Fully Depreciated Assets	80,585	23	23			80,585	73
74								74
75	TOTALS	\$ 218,811	\$ 9,352	\$ 9,352	\$		\$ 157,927	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	4,148				3	4,148	79
80	TOTALS			\$ 20,794	\$	\$	\$		\$ 20,794	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)	\$ 1,416,770	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,793	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,793	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)	\$ 527,385	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.

Facility Name & ID Number Alden of Old Town West

# 0042077

Report Period Beginning: 1/1/10

Ending: 12/31/10

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

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: \$ 4,295 Description: copy mach gl 6861, postage meter gl 6850, & office equip gl 6859

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>related party- Pg 6A</u>	<u>various</u>	\$ <u>230.00</u>	\$ <u>2,760</u>	17
18					18
19	<u>Auto lease GL 6890</u>	<u>various</u>	<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>230.00</u>	\$ <u>2,760</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. /2011 \$ varies

13. /2012 \$ varies

14. /2013 \$ varies

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$ \_\_\_\_\_

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescrpts				(85)		(85)	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>						721		721	13
14	TOTAL			\$		\$	636		\$ 636	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

Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.	
1.	OT	39-3	To Co	\$2,187.13
2.	ST	39-3	To Cc	1,654.02
3.				
4.	PT	39-3	To Cc	4,167.18
5.				
6.				
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type			(8,008.33)
	Pharmacy Supplies per GL			(60.23)
	Manual Input from Related Party- Forum Drugs			(25.00)
9.	Total to line 9 Pharmacy	See Pg 16A	To Cc	(85.23)
10.				
11.				
12.	Exceptional Care-Salaries:	See pg 16A	To Cc	0.00
12.	Exceptional Care-Supplies:	See pg 16A	To Cc	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			1,302.36
	Manual Input: Related Party - Prism			(524.00)
	Manual Input: Related Party FECII - I.V.			
	Manual Input: Related Party FECII - Wound Care Oxygen, from reclass worksheet (Pg 4A)			(57.00)
13.	Col 6: Supplies Total		To Co	721.36
13.	Total Line 13, Column 8			721.36
14.	Total			636.13

Facility Name & ID Number Alden of Old Town West

# 0042077

Report Period Beginning: 1/1/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100 )	101,113	101,113	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,400	6
7	Other Prepaid Expenses	1,301	1,301	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties	6,486	6,486	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 108,900	\$ 114,300	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	29,795	35,794	15
16	Equipment, at Historical Cost	49,285	181,889	16
17	Accumulated Depreciation (book methods)	(63,541)	(429,438)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		19,628	21
22	Other Long-Term Assets (spe Refinance Fee)		15,476	22
23	Other(specify): Due from Affiliates	1,209,059	1,427,142	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,224,598	\$ 2,328,841	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,333,498	\$ 2,443,141	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 161,712	\$ 161,540	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,049	6,049	28
29	Short-Term Notes Payable	2,810	16,296	29
30	Accrued Salaries Payable	49,326	49,326	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,265	7,265	31
32	Accrued Real Estate Taxes(Sch.IX-B)		14,933	32
33	Accrued Interest Payable	1,176	5,535	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Accr Exp/Insur, Due State, Sales Tax, etc.	3,705	3,705	36
37	Due to Affiliates	9,289	9,289	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 241,332	\$ 273,938	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		308,322	39
40	Mortgage Payable		810,220	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,118,542	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 241,332	\$ 1,392,480	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,092,166	\$ 1,050,661	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,333,498	\$ 2,443,141	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,044,267	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	(62,103)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 982,164	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	110,002	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)	\$ 110,002	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,092,166	24 *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,301,071	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,301,071	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 13	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Pg 19A</u>	286,239	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 286,239	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,587,323	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	206,825	31
32	Health Care	486,714	32
33	General Administration	293,505	33
<b>B. Capital Expense</b>			
34	Ownership	124,135	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	293,646	35
36	Provider Participation Fee	72,496	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,477,321	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	110,002	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 110,002	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 - Other	\$ 29
Misc Income - Other	501
Misc Income - Wage Service Fee	14
Gain on Sale of Assets	1,299
Day Training	284,396
Line 28 Total:	<u>\$ 286,239</u>

Facility Name & ID Number Alden of Old Town West

# 0042077

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	3,267	3,481	104,104	29.91
4	Licensed Practical Nurses	1,413	1,579	43,487	27.54
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	115	130	2,672	20.55
14	Head Cook	4,122	4,290	51,109	11.91
15	Cook Helpers/Assistants	360	360	3,587	9.96
16	Dishwashers				16
17	Maintenance Workers	121	130	3,093	23.79
18	Housekeepers	1,421	1,521	18,126	11.92
19	Laundry				19
20	Administrator	488	510	13,525	26.52
21	Assistant Administrator	71	78	2,444	31.33
22	Other Administrative	47	52	1,468	28.23
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	616	693	12,745	18.39
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	23,126	24,522	271,354	11.07
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) Facility Manager	1,904	2,056	37,870	18.42
34	TOTAL (lines 1 - 33)	37,071	39,402	\$ 565,584 *	\$ 14.35

\* 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	100/month	\$ 1,100	1-3
36	Medical Director	250/month	3,000	10-3
37	Medical Records Consultant			37
38	Nurse Consultant			10-3
39	Pharmacist Consultant	32/month	384	10-3
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	414	22,214	11-3
45	Social Service Consultant	2	69	11-3
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	416	\$ 26,767	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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting	12/08	\$ 3,848	3	\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$ 0	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 3,848		\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$	\$	\$	\$

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

# 0042077

Report Period Beginning: 1/1/10

Ending: 12/31/10

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA=\$618 II. Assoc. of HC=\$0
- (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. \$ 7,157 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. \$ 72,496  
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. \$ 8,205 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? No**  
**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.