

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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>I. IDPH License ID Number: <u>004-1277</u></p> <p>Facility Name: <u>Alden-Northmoor Rehabilitation and Health Care Center, Inc.</u></p> <p>Address: <u>5831 N Northwest Hwy</u> <u>Chicago</u> <u>60631</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773)775-8080</u> Fax # <u>(773)775-9672</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/29/1996</u></p> <p>Type of Ownership:</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>In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 724-6622</u> Email Address: _____</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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</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="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Joan Carl</u> (Title) <u>Vice-President</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> 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) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()							

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, Inc.

004-1277 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	198	Skilled (SNF)	198	72,270	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		ICF/DD 16 or Less		0	6
7	198	TOTALS	198	72,270	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	6,317	1,437	9,477	17,231	8
9	SNF/PED					9
10	ICF	43,719	2,835	757	47,311	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,036	4,272	10,234	64,542	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.31%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 3/29/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 198 and days of care provided 7,256

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health # 004-1277 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	596,042	26,827	22,800	645,669	2,136	647,805	(3,613)	644,192		1
2	Food Purchase		473,807		473,807	(20,533)	453,274	(23,840)	429,434		2
3	Housekeeping	189,246	53,722		242,968	2,331	245,299	10,653	255,952		3
4	Laundry	55,686	28,731		84,417	457	84,874		84,874		4
5	Heat and Other Utilities			286,349	286,349		286,349	2,720	289,069		5
6	Maintenance	47,583	231	262,610	310,424	330	310,754	20,327	331,081		6
7	Other (specify):* Related party							11,302	11,302		7
8	TOTAL General Services	888,557	583,318	571,759	2,043,634	(15,279)	2,028,355	17,549	2,045,904		8
	B. Health Care and Programs										
9	Medical Director			26,700	26,700		26,700		26,700		9
10	Nursing and Medical Records	3,512,523	273,374	5,833	3,791,730	(28,991)	3,762,739	57,455	3,820,194		10
10a	Therapy	158,704	3,410	11,788	173,902		173,902		173,902		10a
11	Activities	121,058	1,281	6,604	128,943	721	129,664		129,664		11
12	Social Services	45,078			45,078		45,078		45,078		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Related party							8,389	8,389		15
16	TOTAL Health Care and Programs	3,837,363	278,065	50,925	4,166,353	(28,270)	4,138,083	65,844	4,203,927		16
	C. General Administration										
17	Administrative	115,038			115,038		115,038	129,370	244,408		17
18	Directors Fees										18
19	Professional Services			1,064,306	1,064,306	(14,311)	1,049,995	(970,243)	79,752		19
20	Dues, Fees, Subscriptions & Promotions			123,612	123,612		123,612	(105,238)	18,374		20
21	Clerical & General Office Expenses	233,052	26,676	94,944	354,672	1,469	356,141	346,884	703,025		21
22	Employee Benefits & Payroll Taxes			816,592	816,592	(656)	815,936	(9,074)	806,862		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,595	6,595		6,595	3,895	10,490		24
25	Other Admin. Staff Transportation			3,604	3,604		3,604	22,412	26,016		25
26	Insurance-Prop.Liab.Malpractice			210,995	210,995		210,995	12,113	223,108		26
27	Other (specify):* Related party			4,935	4,935		4,935	67,077	72,012		27
28	TOTAL General Administration	348,090	26,676	2,325,583	2,700,349	(13,498)	2,686,851	(502,804)	2,184,047		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,074,010	888,059	2,948,267	8,910,336	(57,047)	8,853,289	(419,411)	8,433,878		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-Northmoor Rehabilitation and Health Care Center, In #004-1277 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			35,839	35,839		35,839	311,402	347,241			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			165,799	165,799		165,799	464,783	630,582			32
33	Real Estate Taxes			294,063	294,063	(294,063)		301,428	301,428			33
34	Rent-Facility & Grounds			788,160	788,160	294,063	1,082,223	(1,082,223)				34
35	Rent-Equipment & Vehicles			15,669	15,669		15,669	51,642	67,311			35
36	Other (specify):* M.I.P.							51,904	51,904			36
37	TOTAL Ownership			1,299,530	1,299,530		1,299,530	98,936	1,398,466			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		442,014	709,243	1,151,257	57,047	1,208,304	(155,043)	1,053,261			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			288,132	288,132		288,132		288,132			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		442,014	997,375	1,439,389	57,047	1,496,436	(155,043)	1,341,393			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,074,010	1,330,073	5,245,172	11,649,255		11,649,255	(475,518)	11,173,737			45

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

Reclassifications - Pages 3 & 4, Column 5

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(20,533.00)	Employee Meals
	22	20,533.00	Employee Meals
22		(21,189.00)	Uniforms
	10	13,745.00	Uniforms
	1	2,136.00	Uniforms
	3	2,331.00	Uniforms
	4	457.00	Uniforms
	6	330.00	Uniforms
	11	721.00	Uniforms
	21	1,469.00	Uniforms
10		(57,047.00)	Oxygen - to appropriate cost center
	39	57,047.00	Oxygen - to appropriate cost center
33		(294,063.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	294,063.00	Rent - Real Estate Tax on associated landowner (Pg 6)
<u>Others, if any:</u>			
19		(14,311.00)	Clinical Coordinators (Pathway Billing)
	10	14,311.00	Clinical Coordinators (Pathway Billing)
Net		-	

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,111)	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	(7,204)	30		9
10	Interest and Other Investment Income	(617)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,786)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,188)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,485)	20		19
20	Contributions	(23,152)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,426)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,935)	27		24
25	Fund Raising, Advertising and Promotional	(25,205)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (80,109)		\$	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)	(216,683)	Various	34
35	Other- Attach Schedule	(178,726)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (395,409)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (475,518)		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			x		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			x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Alden-Northmoor Rehabilitation and Health Care Center, Inc.

ID# 004-1277

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees on Utilities	\$ (1,138)	5	1
2	Intercompany Interest (7031)	(109,521)	32	2
3	Misc Inc. (g/l 4977-100-000) (W/C Class action suit)	(500)	22	3
4	Record Copies (g/l 4977-100-001)	(1,076)	10	4
5	Jury Duty (g/l 4977-100-002)	(86)	21	5
6	Wage Service Fee (g/l 4977-100-006)	(68)	21	6
7	Marketing Manager Salaries (GL6701-100-009)	(53,099)	21	7
8	Employee Benefits for Marketing Manager	(8,574)	22	8
9	IL Health Care Assoc Dues (PAC: 30%)	(3,279)	20	9
10	Deming Leadership Training (20%)	(500)	24	10
11	Adj for 2008 ABC related party profit - Pg 12	(26)	30	11
12	Adj for 2009 ABC related party profit - Pg 12	(6)	30	12
13	Adj for 2010 ABC related party profit - Pg 12	(2)	30	13
14	Adj for 2011 ABC related party profit - Pg 12	11	30	14
15	Elimin Pg 13 deprec on assets<\$2,500	(14,495)	30	15
16	"Pg 13" assets<\$2,500 to be expensed	14,653	6	16
17	Elimin Pg 12 deprec on assets<\$2,500	(1,370)	30	17
18	"Pg 12" assets<\$2,500 to be expensed	4,877	6	18
19	Adjust depreciation to Pg 13's	3,231	30	19
20	Eliminate Legal fees for Group Midcap Charge	(5,133)	19	20
21	Eliminate Acctng fees for Group Midcap Charge	(2,584)	19	21
22	Back Out Bank Charges - Northmoor Associates	(41)	19	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	(178,726)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, II

004-1277

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	7,150	(10,763)	0	0	0	0	0	0	0	(3,613)	1
2	Food Purchase	(1,786)	0	0	(22,054)	0	0	0	0	0	0	0	(23,840)	2
3	Housekeeping	0	0	10,653	0	0	0	0	0	0	0	0	10,653	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,138)	0	3,858	0	0	0	0	0	0	0	0	2,720	5
6	Maintenance	9,419	0	10,638	0	0	0	270	0	0	0	0	20,327	6
7	Other (specify):*	0	0	10,201	1,101	0	0	0	0	0	0	0	11,302	7
8	TOTAL General Services	6,495	0	42,500	(31,716)	0	0	270	0	0	0	0	17,549	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	(1,076)	0	55,359	34	3,138	0	0	0	0	0	0	57,455	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	8,389	0	0	0	0	0	0	0	0	8,389	15
16	TOTAL Health Care and Programs	(1,076)	0	63,748	34	3,138	0	0	0	0	0	0	65,844	16
	C. General Administration													
17	Administrative	0	0	129,370	0	0	0	0	0	0	0	0	129,370	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,184)	7,465	(968,524)	0	0	0	0	0	0	0	0	(970,243)	19
20	Fees, Subscriptions & Promotions	(53,121)	0	(52,117)	0	0	0	0	0	0	0	0	(105,238)	20
21	Clerical & General Office Expenses	(57,441)	500	346,746	25,801	31,278	0	0	0	0	0	0	346,884	21
22	Employee Benefits & Payroll Taxes	(9,074)	0	0	0	0	0	0	0	0	0	0	(9,074)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(500)	0	4,395	0	0	0	0	0	0	0	0	3,895	24
25	Other Admin. Staff Transportation	0	0	22,412	0	0	0	0	0	0	0	0	22,412	25
26	Insurance-Prop.Liab.Malpractice	0	11,913	200	0	0	0	0	0	0	0	0	12,113	26
27	Other (specify):*	(4,935)	0	67,358	2,753	1,901	0	0	0	0	0	0	67,077	27
28	TOTAL General Administration	(134,255)	19,878	(450,160)	28,554	33,179	0	0	0	0	0	0	(502,804)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(128,836)	19,878	(343,912)	(3,128)	36,317	0	270	0	0	0	0	(419,411)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center,]

004-1277

Report Period Beginning:

1/1/2011 Ending:

12/31/2011

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	(19,861)	323,076	8,187	0	0	0	0	0	0	0	0	311,402	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(110,138)	488,414	85,479	0	1,028	0	0	0	0	0	0	464,783	32
33	Real Estate Taxes	0	294,063	6,921	0	444	0	0	0	0	0	0	301,428	33
34	Rent-Facility & Grounds	0	(1,082,223)	0	0	0	0	0	0	0	0	0	(1,082,223)	34
35	Rent-Equipment & Vehicles	0	0	51,642	0	0	0	0	0	0	0	0	51,642	35
36	Other (specify):*	0	51,904	0	0	0	0	0	0	0	0	0	51,904	36
37	TOTAL Ownership	(129,999)	75,234	152,229	0	1,472	0	0	0	0	0	0	98,936	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	(31,729)	(79,430)	(43,884)	0	0	0	0	0	(155,043)	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	(31,729)	(79,430)	(43,884)	0	0	0	0	0	(155,043)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(258,835)	95,112	(191,683)	(34,857)	(41,641)	(43,884)	270	0	0	0	0	(475,518)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 PG6-Supp		See PG6-Supp		

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 revenue	\$ 1,082,223	Northmoor Associates, LLC		\$	(1,082,223)	1
2	V	32	Interest income	53,527	Northmoor Associates, LLC			(53,527)	2
3	V	32	Replacement Reserve interest	206	Northmoor Associates, LLC			(206)	3
4	V	19	Accounting & Bank Fees		Northmoor Associates, LLC		7,465	7,465	4
5	V	21	Dues & Subscriptions		Northmoor Associates, LLC		500	500	5
6	V	33	Real estate taxes		Northmoor Associates, LLC		294,063	294,063	6
7	V	26	Property/liability insurance		Northmoor Associates, LLC		11,913	11,913	7
8	V	36	Mortgage insurance premium		Northmoor Associates, LLC		51,904	51,904	8
9	V	32	Mortgage interest		Northmoor Associates, LLC		445,700	445,700	9
10	V	32	Interest-Operating loss loan		Northmoor Associates, LLC		94,109	94,109	10
11	V	30	Depreciation		Northmoor Associates, LLC		323,076	323,076	11
12	V	32	Amortization		Northmoor Associates, LLC		2,338	2,338	12
13	V								13
14	Total		\$ 1,135,956			\$ 1,231,068	\$ *	95,112	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	19 Professional Fees	\$ 1,024,778	Alden Management Services, Inc.	0.00%	\$	\$ (1,024,778)
16	V	21 Gen'l & Admin		Alden Management Services, Inc.		346,746	346,746
17	V	5 Utilities		Alden Management Services, Inc.		3,858	3,858
18	V	6 Repair/Mainten.	55,276	Alden Management Services, Inc.		65,914	10,638
19	V	24 Travel/Seminar		Alden Management Services, Inc.		4,395	4,395
20	V	25 Other admin travel		Alden Management Services, Inc.		22,412	22,412
21	V	26 Insurance		Alden Management Services, Inc.		200	200
22	V	20 Dues/Subscriptions	54,882	Alden Management Services, Inc.		2,765	(52,117)
23	V	30 Depreciation		Alden Management Services, Inc.		8,187	8,187
24	V	33 Real Estate Taxes		Alden Management Services, Inc.		6,921	6,921
25	V	35 Rent-Equip & Vehic		Alden Management Services, Inc.		51,642	51,642
26	V	32 Interest		Alden Management Services, Inc.		85,479	85,479
27	V	7 Employee Benefits-Gen Service		Alden Management Services, Inc.		10,201	10,201
28	V	15 Employee Benefits Health Care		Alden Management Services, Inc.		8,389	8,389
29	V	27 Employee Benefits-Admin		Alden Management Services, Inc.		67,358	67,358
30	V	1 Dietary Aide Coordinator Sal.		Alden Management Services, Inc.		7,150	7,150
31	V	3 Housekeeping Coordinator Sal		Alden Management Services, Inc.		10,653	10,653
32	V	10 Nusre & Med Records Sal		Alden Management Services, Inc.		55,359	55,359
33	V	17 Administrative Sal		Alden Management Services, Inc.		129,370	129,370
34	V	19 Professional Salary & Non-Salary		Alden Management Services, Inc.		56,254	56,254
35	V	20 MKT Management Fees		Alden Management Services, Inc.			
36	V						
37	V						
38	V						
39	Total		\$ 1,134,936			\$ 943,253	\$ * (191,683)

* 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	\$ 22,800	Prism Health Care Services, Inc.	0.00%	\$ 380	\$ (22,420)
16	V	1 Dietary salaries		Prism Health Care Services, Inc.		11,657	11,657
17	V	2 Tube feeding	61,189	Prism Health Care Services, Inc.		39,135	(22,054)
18	V	10 Equipment rental-patient care	6,660	Prism Health Care Services, Inc.		6,694	34
19	V	39 Ancillary supplies	52,637	Prism Health Care Services, Inc.		20,908	(31,729)
20	V	21 G & A salaries		Prism Health Care Services, Inc.		16,503	16,503
21	V	21 G & A expenses		Prism Health Care Services, Inc.		9,298	9,298
22	V	27 Emp. Benefits-G & A		Prism Health Care Services, Inc.		2,753	2,753
23	V	7 Emp. Benefits-Dietary		Prism Health Care Services, Inc.		1,101	1,101
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		\$ 143,286			\$ 108,429	\$ * (34,857)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 <u>Drugs</u>	\$ 189,919	<u>Forum Extended Care Services II, Inc.</u>	0.00%	\$ 263,195	\$ 73,276
16	V	39 <u>I.V.</u>	171,775	<u>Forum Extended Care Services II, Inc.</u>		20,192	(151,583)
17	V	39 <u>Wound Vac</u>	5,373	<u>Forum Extended Care Services II, Inc.</u>		4,250	(1,123)
18	V	10 <u>House Stock</u>	15,727	<u>Forum Extended Care Services II, Inc.</u>		14,551	(1,176)
19	V	10 <u>Pharm Consult</u>	5,759	<u>Forum Extended Care Services II, Inc.</u>		10,073	4,314
20	V	27 <u>Employ Vaccin</u>	2,641	<u>Forum Extended Care Services II, Inc.</u>		2,089	(552)
21	V	27 <u>Employ Benefits-G & A</u>		<u>Forum Extended Care Services II, Inc.</u>		2,453	2,453
22	V	21 <u>G & A Salaries</u>		<u>Forum Extended Care Services II, Inc.</u>		19,705	19,705
23	V	21 <u>Gen'l & Admin</u>		<u>Forum Extended Care Services II, Inc.</u>		11,573	11,573
24	V	32 <u>Interest</u>		<u>Forum Extended Care Services II, Inc.</u>		1,028	1,028
25	V	33 <u>Real Estate Tax</u>		<u>Forum Extended Care Services II, Inc.</u>		444	444
26	V	30 <u>Depreciation</u>		<u>Forum Extended Care Services II, Inc.</u>			
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		\$ 391,194			\$ 349,553	\$ * (41,641)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy	\$ 689,810	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 645,926	\$ (43,884)
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		\$ 689,810			\$ 645,926	\$ * (43,884)

* 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 Repair & Maintenance	\$ 34,773	Alden Bennett Construction Company, Inc.	0.00%	\$ 35,043	\$ 270	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		\$ 34,773			\$ 35,043	\$ *	270	39

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

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, Inc. # 004-1277 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Heather Health Care Center, Inc.	Harvey	The Forum Profession	Chicago	Home Office rental	2
3			Alden-Long Grove Rehabilitation and Health Ca	Long Grove				3
4			Alden-Lincoln Park Rehabilitation and Health C	Chicago	Forum Extended Care Se	Chicago	Pharmacy	4
5					Alden Management Serv	Chicago	Management	5
6			Alden-Lakeland Rehabilitation and Health Care (Chicago				6
7			Alden of Old Town East, Inc.	Bloomingtondale	Alden Gardens of Bloom	Bloomingtondale	Supportive Living Fac	7
8			Alden Terrace of McHenry Rehabilitation and He	McHenry	Alden Garden Courts of	DesPlaines	Assisted Living/Alzhei	8
9			Alden - Wentworth Rehabilitation and Health Ca	Chicago	Alden Courts of Waterfo	Aurora	Alzheimers Facility	9
10			Alden Estates of Naperville, Inc.	Naperville	Alden Gardens of Waterf	Aurora	Assisted Living	10
11			Alden - Valley Ridge Rehabilitation and Health C	Bloomingtondale	Prism Health Care Servi	Schaumburg	Nursing and Durable	11
12			Alden Village Health Facility for Children and Yc	Bloomingtondale	Community Physical The	Addison	Therapy Provider	12
13			Alden - Orland Park Rehabilitation and Health C:	Orland Park	Alden Bennett Construct	Chicago	General Contractor	13
14			Alden - Princeton Rehabilitation and Health Car	Chicago	Fort Medical Equipment	Fort Atkinson, WI	Nursing and Durable	14
15			Alden of Old Town West, Inc.	Bloomingtondale	Fort Healthcare, LLC	Fort Atkinson, WI	SNF w/in hospital	15
16			Alden - Town Manor Rehabilitation and Health C	Cicero				16
17			Alden Trails, Inc.	Bloomingtondale				17
18			Alden - Poplar Creek Rehabilitation and Health (Hoffman Estates				18
19			Alden - North Shore Rehabilitation and Health C	Skokie				19
20			Alden - Des Plaines Rehabilitation and Health C:	Des Plaines				20
21			Alden Estates of Evanston, Inc.	Evanston				21
22			Alden - Alma Nelson Manor, Inc.	Rockford				22
23			Alden - Park Strathmoor, Inc.	Rockford				23
24			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				24
25			Alden Estates of Barrington, Inc.	Barrington				25
26			Alden of Waterford, LLC	Aurora				26
27			Alden Springs, Inc.	Bloomingtondale				27
28			Alden Village North, Inc.	Chicago				28
29			Alden Estates of Skokie, Inc.	Skokie				29
30			Alden Estates of Countryside, Inc.	Jefferson, WI				30

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health # 004-1277 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	175,923	1.964	4.91	Salary	\$ 9,077	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	65,272	1.964	4.91	Salary	3,368	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	37,581	1.964	4.91	Salary	1,939	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	\$ 14,384		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-Northmoor Rehabilitation and Health Care Center, # 004-1277 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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 (773-724-6622
 Fax Number (773-724-6622

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	1,315,389	34	\$ 78,619	\$ 64,542	\$ 3,858	1
2	24	Travel/Seminar	Patient days	1,315,389	34	89,570	64,542	4,395	2
3	25	Other Admin Travel	Patient days	1,315,389	34	456,762	64,542	22,412	3
4	26	Insurance	Patient days	1,315,389	34	4,082	64,542	200	4
5	20	Dues/Subscriptions	Patient days	1,315,389	34	56,361	64,542	2,765	5
6	30	Depreciation	No. of Providers	34	34	291,758	1	8,187	6
7	33	Real Estate Tax	Patient days	1,315,389	34	156,401	64,542	6,921	7
8	35	Rent-Equip & Vehicles	Patient days	1,315,389	34	1,052,493	64,542	51,642	8
9	32	Interest	Patient days	1,315,389	34	1,368,621	64,542	85,479	9
10	1	Diet. Salary	Patient days	1,315,389	34	145,718	145,718	7,150	10
11	3	Housekeeping Salary	Patient days	1,315,389	34	217,102	217,102	10,653	11
12	7	Employee Benefits-Gen'l Servs	Patient days	1,315,389	34	207,899	64,542	10,201	12
13	10	Nurs & Med Record Salary	Patient days	1,315,389	34	1,184,449	1,184,449	55,359	13
14	15	Employee Benefits-Health Care	Patient days	1,315,389	34	170,963	64,542	8,389	14
15	17	Administrative Salary	Patient days	1,315,389	34	2,886,253	2,886,253	129,370	15
16	27	Employee Benefits-Administr.	Patient days	1,315,389	34	1,372,783	64,542	67,358	16
17	19	Professional Fees	Patient days	1,315,389	34	1,146,467	654,108	56,254	17
18	21	Gen'l & Administrative	Patient days	1,315,389	34	7,066,809	5,970,419	346,746	18
19	6	Repairs & Maniten.	Patient days	1,315,389	34	1,343,350	1,077,524	65,914	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 19,296,460	\$ 12,135,573	\$ 943,253	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Cambridge Realty		x	Mortgage	\$45,562.32	12/1/03	\$ 9,194,900	\$ 8,524,617	1/1/2044	5.2000	\$ 445,700	1							
2	Cambridge Realty		x	Operating Loss Loan	\$9,620.47	12/1/03	1,941,500	1,799,969	1/1/2044	5.2000	94,110	2							
3	Insurance Interest		x	Medical Malpractice							2,751	3							
4												4							
5												5							
Working Capital																			
6	Related party-AMS		x	Working Capital							85,479	6							
7	Related party-FECH		x	Working Capital							1,028	7							
8												8							
9	TOTAL Facility Related				\$55,182.79		\$ 11,136,400	\$ 10,324,587			\$ 629,068	9							
B. Non-Facility Related*																			
10	Northmoor Associates LLC		x	Interest-Replacement Res							(206)	10							
11	Patient interest income		x	Non-care interest revenue							(30)	11							
12	Interest Income		x	Public Aid Interest							(587)	12							
13	Amortization-Fin/Refin Fee		x								2,337	13							
14	TOTAL Non-Facility Related						\$	\$			\$ 1,514	14							
15	TOTALS (line 9+line14)						\$ 11,136,400	\$ 10,324,587			\$ 630,582	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 51,904 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.)

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 bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	278,300		1
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.)		\$	281,963		2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,663		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	290,400		4
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.)		\$			5
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.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	294,063		7
Real Estate Tax History:			Plus: Related Party Taxes (2) - See Pg RE_Tax		7,365
		\$	301,428		
Real Estate Tax Bill for Calendar Year:	2006	359,680			8
	2007	355,840			9
	2008	359,411			10
	2009	270,157			11
	2010	281,918			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 2010 \$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden-Northmoor Rehabilitation and Health Care Center, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 004-1277

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 724-6622 FAX #: (773-283-3997

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>See attached supplement</u>	<u>Related Party-Alden Management Ser</u>	\$ <u>300,377.00</u>	\$ <u>6,921.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	\$ <u>42,023.00</u>	\$ <u>444.00</u>
3. <u>13-06-409-017-0000</u>	<u>Nursing Home Facility</u>	\$ <u>5,606.15</u>	\$ <u>5,606.15</u>
4. <u>13-06-409-018-0000</u>	<u>Nursing Home Facility</u>	\$ <u>3,356.48</u>	\$ <u>3,356.48</u>
5. <u>13-06-409-019-0000</u>	<u>Nursing Home Facility</u>	\$ <u>3,317.28</u>	\$ <u>3,317.28</u>
6. <u>13-06-409-020-0000</u>	<u>Nursing Home Facility</u>	\$ <u>3,264.57</u>	\$ <u>3,264.57</u>
7. <u>13-06-409-021-0000</u>	<u>Nursing Home Facility</u>	\$ <u>52,830.93</u>	\$ <u>52,830.93</u>
8. <u>13-06-409-022-0000</u>	<u>Nursing Home Facility</u>	\$ <u>52,580.04</u>	\$ <u>52,580.04</u>
9. <u>13-06-409-023-0000</u>	<u>Nursing Home Facility</u>	\$ <u>52,580.04</u>	\$ <u>52,580.04</u>
10. <u>13--06-409-024, 025-000</u>	<u>Nursing Home Facility</u>	\$ <u>108,382.29</u>	\$ <u>108,382.29</u>
TOTALS		\$ <u><u>624,317.78</u></u>	\$ <u><u>289,282.78</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden-Northmoor Rehabilitation and Health Care Center, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 004-1277

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,872 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing facility</u>	<u>53,009</u>	<u>1996</u>	<u>\$ 1,429,683</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	53,009		\$ 1,429,683	3

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	198			1994	\$ 8,796,651	\$ 227,120	40	\$ 219,916	\$	\$ 3,501,306	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cable installation			1996	5,704		5			5,704	9
10	Cable installation			1996	3,286		5			3,286	10
11	Fire alarm			1996	17,753	886	15	886		17,753	11
12	Install additional outlet			1997	2,108		10			2,319	12
13	Install additional outlet			1997	1,116		10			1,116	13
14	Install additional outlet			1997	2,668		10			2,668	14
15	Access control materials			1997	4,714		10			4,714	15
16	HVAC repair			1997	6,413		5			6,413	16
17	Phone line installation			1997	2,768		5			2,768	17
18	Phone line installation			1997	3,096		5			3,096	18
19	Equipment for security system			1998	4,170		10			4,170	19
20	Change belt on fans & airhandlers			1998	2,012		5			2,012	20
21	Wire third floor & twenty bed jacks			1998	7,189		10			7,189	21
22	Repair pump motor on elevator			1998	3,500	175	20	175		2,187	22
23	Install pump motor on dishwasher			1998	2,029		10			2,029	23
24	Install door locks			1998	8,157		10			8,157	24
25	Door system work			1998	775		10			775	25
26	Repair nurse call system			1998	275		10			275	26
27	Repair nurse call system			1998	1,032		10			1,032	27
28	Repair nurse call system			1998	982		10			982	28
29	Chiller			1998	52,667	3,511	15	3,511		45,937	29
30	Computer & training & installation			1998	3,158		5			3,158	30
31	Canopy construction			1998	73,120	4,875	15	4,875		67,028	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, Inc.

004-1277

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Climate Service - replace compressor	1999	\$ 2,603	\$ 173	15	\$ 173	\$	\$ 2,253	37
38	Washtown equipment - dryer installation	1999	2,875		10			2,875	38
39	Climate Service - repair chiller pump	1999	2,940		5			2,940	39
40	Equipment INT - dryer repair	1999	130		5			130	40
41	Rykoff Sexton - coffee machine	1999	2,021		5			2,021	41
42	Equipment INT - dryer repair	1999	1,891		5			1,891	42
43	Climate Service - chiller maint	1999	3,071		5			3,071	43
44	United Communication group-phone repair	1999	1,593		10			1,593	44
45	Long elevator	1999	2,168	108	20	108		1,317	45
46	Climate service - ice machine repair	1999	1,885		10			1,885	46
47	Climate service - condensor repair	1999	3,579		15			3,579	47
48	ABC -misc. Work	2000	16,003		10			16,003	48
49	CSI-change exhausst belt - hvac	2000	1,695		5			1,695	49
50	ABC - metla frame/heating vent	2000	2,048	102	20	102		1,210	50
51	ABC - misc. const. Work	2000	2,059		5			2,059	51
52	GT mechanical - gas line	2001	1,563		10			1,563	52
53	Coker services-repair washer	2001	2,013	35	10	35		2,013	53
54	Coker services -install gas unit	2001	4,125	67	10	67		4,125	54
55	DBS contracting -lawn sprinkler	2001	2,215	148	15	148		1,700	55
56	DBS contracting -lawn sprinkler	2001	2,575	172	15	172		1,919	56
57	GT mechanical -condensor fan motors	2001	1,867	124	15	124		1,324	57
58	CSI Corker - service on cleveland MD2224CGA1	2001	1,582	133	10	133		1,582	58
59	GT Mech- chiller repair (both chillers)	2002	1,435		5			1,435	59
60	GT Mech- credit for 5/01 inv 18186	2002	(1,259)	(84)	15	(84)		(827)	60
61	Action Fence Contractors-install 3 steel bollards	2002	1,725	172	10	172		1,665	61
62	ABC- Efficient Insulation Systems- insulation	2002	769	51	15	51		486	62
63	ABC- Joseph Stanger corian top repair	2002	1,632	163	10	163		1,495	63
64	ABC- 30' flagpole and installation	2002	2,215	111	20	111		963	64
65	ABC- Action Fence install 3 steel bollards	2002	2,011	201	10	201		1,860	65
66	ABC- Action Fence dumpster gate	2002	2,332		5			2,332	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,078,705	\$ 238,243		\$ 231,039	\$	\$ 3,764,231	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12A, Carried Forward		\$ 9,078,705	\$ 238,243		\$ 231,039	\$ (7,204)	\$ 3,764,231	1
2	ABC-fire/smoker dampers	2003	6,390	639	10	639		5,431	2
3	ABC-rooftop compressor	2003	8,411	561	15	561		4,814	3
4	ABC-securitron DK 26	2003	1,087	72	15	72		626	4
5	GT Mechanical - H/V/A/C	2004	2,594	259	10	259		1,965	5
6	CSI Coker - Oven (flame spreader)	2004	3,378	338	10	338		2,535	6
7	ABC - Elevator finish (handrails/baseboard)	2004	2,150	179	12	179		1,328	7
8	ABC - Elevator finish (handrails/baseboard)	2004	2,150	179	12	179		1,283	8
9	Top Notch Service - Steam wells (2)	2004	2,153	215	10	215		1,524	9
10	ABC (C&H Bldg Spec)-30' flagpole & installation	2005	2,193	110	20	110		724	10
11	Equipment Int'l-#1 American Dryer repl parts	2005	2,007	201	10	201		1,390	11
12	ABC (JJ Designs)-Refurbish rooms/furniture/board trim	2005	5,324	355	15	355		2,396	12
13	Lees (The Floor Source)-4th floor dining room tiling	2005	5,702	570	10	570		3,705	13
14	ABC (Stripe-It-Right)-Sealcoat & stripe	2005	2,029	203	10	203		1,302	14
15	ABC (SCI Design)-Refurbish/finish furniture	2005	4,326	288	15	288		1,824	15
16	ABC (Amer Bldg Serv)-Restroom doors	2005	759	40	20	40		247	16
17	ABC (Raise-Rite Concrete)-Mud jack ambulance entry/patio	2005	1,020	68	15	68		419	17
18	ABC (Oak Fire)-Smoke detectors for elevator recall system	2006	13,931	1,393	10	1,393		6,269	18
19	GT Mechanical-Compressor fan motor & cooling fans	2006	4,097	410	10	410		1,686	19
20	Long Elevator-New motor/relays/starter	2006	7,333	336	20	336		1,527	20
21	Oak Fire & Security - Smoke Detectors	2007	3,020	302	10	302		1,133	21
22	ABC Electrical Work	2007	24,463	1,223	20	1,223		4,179	22
23	Tarkett flooring	2008	8,745	1,749	5	1,749		6,705	23
24	Plumbing work & fixtures combined	2008	9,526	476	20	476		1,706	24
25	Replaced numerous plumbing fixtures	2008	9,806	490	20	490		1,593	25
26	Heating Vent	2008	8,838	589	15	589		1,914	26
27	Replaced numerous plumbing fixtures	2008	8,440	422	20	422		1,372	27
28	Replaced plumbing fixtures	2008	7,520	376	20	376		1,222	28
29	Repair of major water leak	2008	8,213	821	10	821		2,600	29
30	Replaced paio doors (automatic)	2008	3,012	301	10	301		928	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,247,322	\$ 251,409		\$ 244,205	\$ (7,204)	\$ 3,828,578	34

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

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, Inc.

004-1277

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		\$ 9,247,322	\$ 251,409		\$ 244,205	\$ (7,204)	\$ 3,828,578	1
2	ABC - Heating/Vent	2009	8,838	589	15	589		1,424	2
3	RE-UPHOLSTERED 1ST FL Furniture	2009	7,445	745	10	745		1,551	3
4	ABC - Install Fire Dampers	2010	13,646	1,365	10	1,365		1,365	4
5	GTMECH - Fan motor/blade replaced in chiller	2011	4,054	338	5	338		338	5
6	ROSPAV-Asphalt/Painting/Coating/Sealing for Parking Lot	2011	10,383	324	8	324		324	6
7	ABC - Boiler Pipes/Plumbing Repairs	2011	8,018	27	25	27		27	7
8	ABC - Window Panel Replacement	2011	2,768		10				8
9	TOPNOT - Booster Plumbing	2011	5,421	542	5	542		542	9
10	OAKFIR - Annunciator card replaced	2011	4,775	80	5	80		80	10
11	ABC - Fire Dampers installed	2011	13,646	114	10	114		114	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19	Adj for ABC related party profit	2008	(319)	(26)		(26)		(91)	19
20	Adj for ABC related party profit	2009	(117)	(6)		(6)		(15)	20
21	Adj for ABC related party profit	2010	(167)	(2)		(2)		(2)	21
22	Adj for ABC related party profit	2011	190	11		11		11	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,325,902	\$ 255,509		\$ 248,305	\$ (7,204)	\$ 3,834,246	34

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

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, Inc.

004-1277

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 9,325,902	\$ 255,509		\$ 248,305	\$ (7,204)	\$ 3,834,246	1
2	Forum Prof Ctr: Remodeling	1979	13,418		20			13,418	2
3	Forum Prof Ctr: Build Improv - multiple	1980	26,131		15			26,131	3
4	Forum Prof Ctr: Tennant Improv	1986	824		13			824	4
5	Forum Prof Ctr: AMS remodel	1990	5,604		10			5,604	5
6	Forum Prof Ctr: Roof	1994	2,956		16			2,956	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,042	65	16	65		1,039	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,646	13	10	13		1,605	8
9	Forum Prof Ctr: Remodel/electrical	2001	641	24	7	24		595	9
10	Forum Prof Ctr: bathroom remodel	2002	567	53	5	53		527	10
11	Forum Prof Ctr: remodel suites/etc.	2003	729	74	9	74		657	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,245	104	7	104		1,954	12
13	Forum Prof Ctr: Suite renovation	2005	453	27	10	27		537	13
14	Forum Prof Ctr: Superior installations, etc.	2006	108	3	4	3		108	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	435	68	7	68		294	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	374	54	7	54		208	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	761	73	7	73		162	17
18	Forum Prof Ctr: Building Renovations	2010	1,296	263	7	263		340	18
19	Forum Prof Ctr: Building Renovations	2011	5,684	137	7	137		137	19
20	Alden Mgt Servs: Remodel suites	1993	6,963		7			6,963	20
21	Alden Mgt Servs: Remodel suites	2002	290		7			290	21
22	Alden Mgt Servs: Remodel suites	2003	6,295					6,295	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,404,365	\$ 256,467		\$ 249,263	\$ (7,204)	\$ 3,904,890	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 612,320	\$ 75,981	\$ 75,981	\$		\$ 197,582	71
72	Current Year Purchases	47,587	4,153	4,153			4,153	72
73	Fully Depreciated Assets	1,192,832	17,844	17,844			1,192,832	73
74								74
75	TOTALS	\$ 1,852,739	\$ 97,978	\$ 97,978	\$		\$ 1,394,567	75

D. Vehicle Costs. (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	Buses	Ford Eldorado	10/1/2000	\$ 49,863	\$	\$	\$	3	\$ 49,863	76
77										77
78										78
79	Related party - AMS	Various	98-02	4,026				3	4,026	79
80	TOTALS			\$ 53,889	\$	\$	\$		\$ 53,889	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)	\$ 12,740,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 354,445	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 347,241	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,204)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,353,346	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 eliminated

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: \$ 17,816 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>#####</u>	\$ <u>35,078</u>	17
18					18
19	<u>Auto lease GL 6890</u>	<u>various</u>	<u>0.00</u>		19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>35,078</u>	21

10. Effective dates of current rental agreement:

Beginning 4/1/2006

Ending 3/31/2016

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

Fiscal Year Ending Annual Rent

12. /2012 \$ 1,196,700

13. /2013 \$ 1,196,700

14. /2014 \$ 1,196,700

* 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 307,373	\$		\$ 307,373	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			56,906			56,906	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			325,531			325,531	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16A	# of prescripts				263,195		263,195	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-1,39-3, if any								12
13	Other (specify):	See Pg 16A				(43,884)	144,140		100,256	13
14	TOTAL			\$		\$ 645,926	\$ 407,335		\$ 1,053,261	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 Col 5		\$307,372.58
2.	ST		39-3	To Col 5		56,906.41
3.						
4.	PT		39-3	To Col 5		325,531.08
5.						
6.						
7.						
8.						
	Pharmacy Supplies per GL					189,918.97
	Manual Input from Related Party- Forum Drugs					73,276.00
9.	Total to line 9 Pharmacy		See Pg 16A	To Col 6		263,194.97
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		(43,884.00)
	Other					271,527.55
	Manual Input: Related Party - Prism					(31,729.00)
	Manual Input: Related Party FECII - I.V.					(151,583.00)
	Manual Input: Related Party FECII - Wound Care					(1,123.00)
	Oxygen, from reclass worksheet (Pg 4A)					57,047.00
13.	Col 6: Supplies Total			To Col 6		144,139.55
13.	Total Line 13, Column 8					144,139.55
14.	Total					1,053,260.59

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, In# 004-1277 Report Period Beginning: 1/1/2011Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u>)	<u>4,230,163</u>	<u>4,230,163</u>	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		<u>12,727</u>	5
6	Prepaid Insurance		<u>11,525</u>	6
7	Other Prepaid Expenses	<u>6,657</u>	<u>10,978</u>	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	<u>235,471</u>	<u>414,961</u>	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,472,291	\$ 4,680,354	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		<u>1,429,683</u>	13
14	Buildings, at Historical Cost		<u>9,084,793</u>	14
15	Leasehold Improvements, at Historical Cost	<u>442,418</u>	<u>894,975</u>	15
16	Equipment, at Historical Cost	<u>335,805</u>	<u>1,553,550</u>	16
17	Accumulated Depreciation (book methods)	<u>(618,704)</u>	<u>(5,362,293)</u>	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		<u>244,168</u>	21
22	Other Long-Term Assets (spe <u>Acc Assets/Refi fees</u>)		<u>47,261</u>	22
23	Other(specify): <u>Due from affiliates</u>	<u>16,305,607</u>	<u>17,350,232</u>	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,465,126	\$ 25,242,369	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 20,937,417	\$ 29,922,722	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ <u>827,229</u>	\$ <u>827,262</u>	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	<u>186,275</u>	<u>186,275</u>	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	<u>461,142</u>	<u>461,142</u>	30
31	Accrued Taxes Payable (excluding real estate taxes)	<u>76,702</u>	<u>76,702</u>	31
32	Accrued Real Estate Taxes(Sch.IX-B)		<u>290,400</u>	32
33	Accrued Interest Payable	<u>4,436</u>	<u>49,176</u>	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accr Exp, Due HFS, Sales Tax, Etc.</u>	<u>230,707</u>	<u>230,707</u>	36
37	<u>Due to Affiliates/ST portion of LT Debt</u>	<u>1,131,680</u>	<u>1,260,025</u>	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,918,171	\$ 3,381,689	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		<u>1,777,594</u>	39
40	Mortgage Payable		<u>8,418,648</u>	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to affiliates</u>			43
44	<u>S/holder loans, others</u>		<u>69,927</u>	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,266,169	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,918,171	\$ 13,647,857	46
47	TOTAL EQUITY(page 18, line 24)	\$ 18,019,246	\$ 16,274,865	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 20,937,417	\$ 29,922,722	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 16,458,326	1
2	Restatements (describe):		2
3	external audit adjustment made after 2006 cost report	(62,995)	3
4	was submitted. These have no effect on prior year's report.		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 16,395,331	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,623,915	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)	\$ 1,623,915	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)	\$ 18,019,246	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care (# 004-1277 Report Period Beginning: 1/1/2011

Ending: 12/31/2011

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	\$ 13,121,032	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,121,032	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,365	6
7	Oxygen	44,639	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 144,004	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,241	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	434	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,675	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	617	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 617	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Income & Gain on Sale of Assets - PG 19A</u>	4,842	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,842	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,273,170	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,043,634	31
32	Health Care	4,166,353	32
33	General Administration	2,700,349	33
B. Capital Expense			
34	Ownership	1,299,530	34
C. Ancillary Expense			
35	Special Cost Centers	1,151,257	35
36	Provider Participation Fee	288,132	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,649,255	40
41	Income before Income Taxes (line 30 minus line 40)**	1,623,915	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,623,915	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.

Facility Name & ID Number Alden-Northmoor Rehabilitation and Heal # 001-7319 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Misc Income (W/C Class Action Suit)	500.00
Misc Income (Record copies)	1,076.00
Misc Income (Jury Duty)	86.00
Misc Income (Wage Service fees)	68.00
Gain on Sale of Assets	3,112.00

Line 28 Total: 4,842

Facility Name & ID Number Alden-Northmoor Rehabilitation and Health Care Center, I

004-1277

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	2,056	2,270	\$ 111,747	\$ 49.23	1
2	Assistant Director of Nursing	2,224	2,277	88,832	39.01	2
3	Registered Nurses	26,452	28,412	970,579	34.16	3
4	Licensed Practical Nurses	29,358	30,917	826,505	26.73	4
5	CNAs & Orderlies	93,957	101,961	1,235,494	12.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,053	4,251	48,765	11.47	8
9	Activity Director	2,080	2,080	41,873	20.13	9
10	Activity Assistants	7,210	7,812	79,184	10.14	10
11	Social Service Workers	2,040	2,040	45,078	22.10	11
12	Dietician					12
13	Food Service Supervisor	2,072	2,080	49,290	23.70	13
14	Head Cook	2,100	2,100	86,505	41.19	14
15	Cook Helpers/Assistants	35,793	39,195	460,246	11.74	15
16	Dishwashers					16
17	Maintenance Workers	2,072	2,072	47,583	22.96	17
18	Housekeepers	17,641	18,664	189,246	10.14	18
19	Laundry	5,314	5,723	55,686	9.73	19
20	Administrator	2,080	2,080	74,158	35.65	20
21	Assistant Administrator	2,080	2,080	40,880	19.65	21
22	Other Administrative	11,321	11,381	281,167	24.70	22
23	Office Manager	1,940	1,940	31,461	16.22	23
24	Clerical	3,308	3,322	30,364	9.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,288	4,288	129,995	30.32	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Unit Director	2,080	2,080	44,095	21.20	32
33	Other(specify) Alz Staff	7,134	7,605	105,277	13.84	33
34	TOTAL (lines 1 - 33)	268,653	286,630	\$ 5,074,010 *	\$ 17.70	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	Monthly	\$ 22,800	1-3	35
36	Medical Director	Monthly	26,700	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,752	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Varies	884	11-3	44
45	Social Service Consultant	Varies	840	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,976		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-Northmoor Rehabilitation and Health Care Center, Inc.

004-1277

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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 = \$7651 Il. Assoc of HC=\$2376
- (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. \$ 60,583 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? _____
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. \$ 288,132
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. \$ 20,533 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.