

		FOR BHF USE					

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**2012**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2012)**

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>0042051</u></p> <p><b>Facility Name:</b> <u>Alden Trails</u></p> <p><b>Address:</b> <u>273 Army Trail Road</u> <u>Bloomington</u> <u>60108</u>  Number City Zip Code</p> <p><b>County:</b> <u>DuPage</u></p> <p><b>Telephone Number:</b> <u>(630)671-1990</u> <b>Fax #</b> <u>(630)671-0540</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>01/01/2012</u> to <u>12/31/2012</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) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  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) _____ (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) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )							

Facility Name & ID Number Alden Trails

# 0042051 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	5,856	6
7	16	TOTALS	16	5,856	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
		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	5,516			5,516	13
14	TOTALS	5,516			5,516	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.19%

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

34 (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 8/15/98

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: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name &amp; ID Number

Alden Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

**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	58,134	3,297	1,200	62,631	1,120	63,751	57	63,808		1
2	Food Purchase		46,289		46,289	(6,975)	39,314	(6,927)	32,387		2
3	Housekeeping	20,690	7,678		28,368		28,368	622	28,990		3
4	Laundry		4,021		4,021		4,021		4,021		4
5	Heat and Other Utilities			20,626	20,626		20,626	252	20,878		5
6	Maintenance	3,257		87,971	91,228		91,228	(436)	90,792		6
7	Other (specify):* <b>related party</b>							907	907		7
8	<b>TOTAL General Services</b>	82,081	61,285	109,797	253,163	(5,855)	247,308	(5,525)	241,783		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,550	3,550		3,550		3,550		9
10	Nursing and Medical Records	383,145	20,642	1,061	404,848	912	405,760	4,675	410,435		10
10a	Therapy		409		409	11,545	11,954	754	12,708		10a
11	Activities	9,806		23,321	33,127		33,127		33,127		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>related party</b>							647	647		15
16	<b>TOTAL Health Care and Programs</b>	392,951	21,051	27,932	441,934	12,457	454,391	6,076	460,467		16
	<b>C. General Administration</b>										
17	Administrative	16,350			16,350		16,350	12,081	28,431		17
18	Directors Fees										18
19	Professional Services			78,916	78,916		78,916	(69,404)	9,512		19
20	Dues, Fees, Subscriptions & Promotions			14,940	14,940		14,940	(13,252)	1,688		20
21	Clerical & General Office Expenses	28,071	1,207	14,088	43,366		43,366	30,586	73,952		21
22	Employee Benefits & Payroll Taxes			86,694	86,694	4,943	91,637		91,637		22
23	Inservice Training & Education										23
24	Travel and Seminar			289	289		289	97	386		24
25	Other Admin. Staff Transportation			4,100	4,100		4,100	1,797	5,897		25
26	Insurance-Prop.Liab.Malpractice			16,852	16,852		16,852	1,826	18,678		26
27	Other (specify):* <b>related party</b>			150	150		150	5,854	6,004		27
28	<b>TOTAL General Administration</b>	44,421	1,207	216,029	261,657	4,943	266,600	(30,415)	236,185		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	519,453	83,543	353,758	956,754	11,545	968,299	(29,864)	938,435		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 Trails

#0042051

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

12/31/2012

## 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			5,851	5,851		5,851	44,453	50,304			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,968	28,968		28,968	60,445	89,413			32
33	Real Estate Taxes							18,498	18,498			33
34	Rent-Facility & Grounds			86,172	86,172		86,172	(86,172)				34
35	Rent-Equipment & Vehicles			8,364	8,364		8,364	5,431	13,795			35
36	Other (specify):* MIP							6,687	6,687			36
37	<b>TOTAL Ownership</b>			129,355	129,355		129,355	49,342	178,697			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,123	11,545	29,668	(11,545)	18,123	(8,980)	9,143			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,498	71,498		71,498		71,498			42
43	Other (specify):* TranSp,DayTrain	7,142		239,964	247,106		247,106		247,106			43
44	<b>TOTAL Special Cost Centers</b>	7,142	18,123	323,007	348,272	(11,545)	336,727	(8,980)	327,747			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	526,595	101,666	806,120	1,434,381		1,434,381	10,498	1,444,879			45

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

Alden Trails  
 Report Period Beginning: 01/01/2012  
 Report Period Ending: 12/31/2012

IDPH Facility No. 0042051

**Reclassifications - Pages 3 & 4, Column 5**

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(6,974.63)	Employee Meals
	22	6,974.63	Employee Meals
22		(2,032.41)	Uniforms
	1	1,120.47	Uniforms
	10	911.94	Uniforms
10			Oxygen - to appropriate cost center
	39		Oxygen - to appropriate cost center
39		(11,545.35)	PT, OT, ST CPT Therapy Costs
	10A	11,545.35	PT, OT, ST CPT Therapy Costs



Facility Name & ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	(130)	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				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	(1,901)	21		17
18	Fines and Penalties				18
19	Entertainment	(23)	20		19
20	Contributions	(1,414)	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	(150)	27		24
25	Fund Raising, Advertising and Promotional	(2,023)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (5,641)		\$	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)	30,531	Various	34
35	Other- Attach Schedule	(14,392)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 16,139		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 10,498		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## Alden Trails

ID#	0042051
Report Period Beginning:	01/01/2012
Ending:	12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (978)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(3,339)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	316	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	3,589	6	4
5	Reconcile Depreciation expense	1,654	30	5
6	Elim ABC Deprec Exp from Pg 12 series -		30	6
7	Late Fees on Utilities	(101)	5	7
8	Intercompany Interest	(14,924)	32	8
9	Misc Income - Wage Service Fee		22	9
10	Back out 30% of PAC Fees IHCA	(265)	20	10
11	Prior Year Accrual Adj RE Tax		33	11
12	Back out Group MidCap Legal Fees	(133)	19	12
13	Back out Group MidCap Accounting Fees	(209)	19	13
14	Back out Deferred Maintenance		6	14
15	Bloomington Chamber Dues Back out		20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(14,392)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

## 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	556	(499)	0	0	0	0	0	0	0	57	1
2	Food Purchase	0	0	0	(6,927)	0	0	0	0	0	0	0	(6,927)	2
3	Housekeeping	0	0	622	0	0	0	0	0	0	0	0	622	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(101)	0	353	0	0	0	0	0	0	0	0	252	5
6	Maintenance	3,774	0	(4,790)	0	0	0	580	0	0	0	0	(436)	6
7	Other (specify):*	0	0	690	217	0	0	0	0	0	0	0	907	7
8	<b>TOTAL General Services</b>	<b>3,673</b>	<b>0</b>	<b>(2,569)</b>	<b>(7,209)</b>	<b>0</b>	<b>0</b>	<b>580</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,525)</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	4,434	5	236	0	0	0	0	0	0	4,675	10
10a	Therapy	0	0	0	0	0	754	0	0	0	0	0	754	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	647	0	0	0	0	0	0	0	0	647	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>5,081</b>	<b>5</b>	<b>236</b>	<b>754</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6,076</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	12,081	0	0	0	0	0	0	0	0	12,081	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(342)	2,917	(71,979)	0	0	0	0	0	0	0	0	(69,404)	19
20	Fees, Subscriptions & Promotions	(3,725)	32	(9,559)	0	0	0	0	0	0	0	0	(13,252)	20
21	Clerical & General Office Expenses	(1,901)	0	28,146	3,908	433	0	0	0	0	0	0	30,586	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	97	0	0	0	0	0	0	0	0	97	24
25	Other Admin. Staff Transportation	0	0	1,797	0	0	0	0	0	0	0	0	1,797	25
26	Insurance-Prop.Liab.Malpractice	0	1,799	27	0	0	0	0	0	0	0	0	1,826	26
27	Other (specify):*	(150)	0	5,540	445	19	0	0	0	0	0	0	5,854	27
28	<b>TOTAL General Administration</b>	<b>(6,118)</b>	<b>4,748</b>	<b>(33,850)</b>	<b>4,353</b>	<b>452</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(30,415)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(2,445)</b>	<b>4,748</b>	<b>(31,338)</b>	<b>(2,851)</b>	<b>688</b>	<b>754</b>	<b>580</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,864)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2012 Ending:

Summary B

12/31/2012

## 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	(2,664)	37,507	9,610	0	0	0	0	0	0	0	0	44,453	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,924)	63,142	12,224	0	3	0	0	0	0	0	0	60,445	32
33	Real Estate Taxes	0	17,833	661	0	4	0	0	0	0	0	0	18,498	33
34	Rent-Facility & Grounds	0	(86,172)	0	0	0	0	0	0	0	0	0	(86,172)	34
35	Rent-Equipment & Vehicles	0	0	5,431	0	0	0	0	0	0	0	0	5,431	35
36	Other (specify):*	0	6,687	0	0	0	0	0	0	0	0	0	6,687	36
37	<b>TOTAL Ownership</b>	<b>(17,588)</b>	<b>38,997</b>	<b>27,926</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>49,342</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	(9,369)	389	0	0	0	0	0	0	(8,980)	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>(9,369)</b>	<b>389</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,980)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(20,033)</b>	<b>43,745</b>	<b>(3,412)</b>	<b>(12,220)</b>	<b>1,084</b>	<b>754</b>	<b>580</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10,498</b>	<b>45</b>

**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 Rental Income	\$ 86,172	Alden of Bloomingdale Limited Partnership		\$	\$ (86,172)	1
2	V	32 Interest Income - RR	16	Alden of Bloomingdale Limited Partnership			(16)	2
3	V	32 Interest Income	13,812	Alden of Bloomingdale Limited Partnership			(13,812)	3
4	V	32 Debt retirement fee		Alden of Bloomingdale Limited Partnership		8,038	8,038	4
5	V	19 Accounting Fees		Alden of Bloomingdale Limited Partnership		2,625	2,625	5
6	V	20 Dues & Subscriptions/Licenses & Inspections		Alden of Bloomingdale Limited Partnership		32	32	6
7	V	33 Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		17,833	17,833	7
8	V	26 General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,799	1,799	8
9	V	36 Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		6,687	6,687	9
10	V	32 Interest - Mortgage/ IOD		Alden of Bloomingdale Limited Partnership		53,793	53,793	10
11	V	19 Legal fees: Non-collections		Alden of Bloomingdale Limited Partnership		292	292	11
12	V	30 Depreciation Expense		Alden of Bloomingdale Limited Partnership		37,507	37,507	12
13	V	32 Amortization Expense		Alden of Bloomingdale Limited Partnership		15,139	15,139	13
14	Total		\$ 100,000			\$ 143,745	\$ * 43,745	14

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

Facility Name & ID Number Alden Trails# 0042051Report Period Beginning: 01/01/2012 Ending: 12/31/2012

## 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%	\$ 353	\$	353	15
16	V	24 Travel & Seminar		Alden Management Services, Inc.		97		97	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		1,797		1,797	17
18	V	26 Insurance		Alden Management Services, Inc.		27		27	18
19	V	20 Dues & Subscriptions	9,840	Alden Management Services, Inc.		281		(9,559)	19
20	V	30 Depreciation		Alden Management Services, Inc.		9,610		9,610	20
21	V	33 Real Estate Taxes		Alden Management Services, Inc.		661		661	21
22	V	35 Rent - Equipment & Vehicles		Alden Management Services, Inc.		5,431		5,431	22
23	V	32 Interest		Alden Management Services, Inc.		12,224		12,224	23
24	V	1 Dietary		Alden Management Services, Inc.		556		556	24
25	V	3 Houskeeping		Alden Management Services, Inc.		622		622	25
26	V	7 Employee Benefits - Gen'l Services		Alden Management Services, Inc.		690		690	26
27	V	10 Nursing & Medical Records Salaries		Alden Management Services, Inc.		4,434		4,434	27
28	V	15 Employee Benefits - Health Care		Alden Management Services, Inc.		647		647	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		12,081		12,081	29
30	V	27 Employee Benefits - Admin		Alden Management Services, Inc.		5,540		5,540	30
31	V	19 Professional Fees	76,172	Alden Management Services, Inc.		4,193		(71,979)	31
32	V	21 General & Administrative		Alden Management Services, Inc.		28,146		28,146	32
33	V	6 Repairs & Maintenance	10,794	Alden Management Services, Inc.		6,004		(4,790)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 96,806			\$ 93,394	\$ *	(3,412)	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	\$ 1,200	Prism Health Care Sevices, Inc.	0.00%	\$ 5	\$ (1,195)	15
16	V	1 Dietary Salary		Prism Health Care Sevices, Inc.		696	696	16
17	V	2 Tube Feeding	8,667	Prism Health Care Sevices, Inc.		1,740	(6,927)	17
18	V	10 Equipment Rental	360	Prism Health Care Sevices, Inc.		365	5	18
19	V	39 Ancillary Supplies	16,014	Prism Health Care Sevices, Inc.		6,645	(9,369)	19
20	V	21 Gen'l & Admin Salary		Prism Health Care Sevices, Inc.		2,717	2,717	20
21	V	27 Employee Benefits		Prism Health Care Sevices, Inc.		445	445	21
22	V	7 Employee Benefits		Prism Health Care Sevices, Inc.		217	217	22
23	V	21 General & Administrative		Prism Health Care Sevices, Inc.		1,191	1,191	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		\$ 26,241			\$ 14,021	\$ * (12,220)	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	\$ 1,702	Forum Extended Care Services II, Inc.	0.00%	\$ 2,174	\$ 472	15
16	V	39 Wound Care	406	Forum Extended Care Services II, Inc.		323	(83)	16
17	V	10 House Stock	1,980	Forum Extended Care Services II, Inc.		1,831	(149)	17
18	V	10 Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		769	385	18
19	V	27 Employee Vaccination	73	Forum Extended Care Services II, Inc.		58	(15)	19
20	V	27 Employee Benefits: G & A		Forum Extended Care Services II, Inc.		34	34	20
21	V	21 Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		246	246	21
22	V	21 Gen'l & Admin.		Forum Extended Care Services II, Inc.		187	187	22
23	V	32 Interest		Forum Extended Care Services II, Inc.		3	3	23
24	V	33 Real Estate Tax		Forum Extended Care Services II, Inc.		4	4	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		\$ 4,545			\$ 5,629	\$ * 1,084	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	\$ 11,545	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 12,299	\$ 754	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	<b>Total</b>		\$ 11,545			\$ 12,299	\$ *	754	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	6 Repairs & Maintenance	\$ 9,399	Alden Bennett Construction Company, Inc.	0.00%	\$ 9,979	\$ 580	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		\$ 9,399			\$ 9,979	\$ *	580	39

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

Facility Name & ID Number

Alden Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

## 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	184,239	0.164	0.00	Salary	\$ 761	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,357	0.164	0.00	Salary	283	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,357	0.164	0.00	Salary	163	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	\$ 1,207		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 Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number ( 773-286-3883  
 Fax Number ( 773-286-8038

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,340,098	35	\$ 85,836	\$ 5,516	\$ 353	1
2	24	Trav & Seminar	Patient Days	1,340,098	35	23,644	5,516	97	2
3	25	Other Admin Travel	Patient Days	1,340,098	35	436,530	5,516	1,797	3
4	26	Insurance	Patient Days	1,340,098	35	6,589	5,516	27	4
5	20	Dues & Subscriptions	Patient Days	1,340,098	35	68,371	5,516	281	5
6	30	Depreciation	No of Providers/usage	35	35	340,112	1	9,610	6
7	33	Real Estate Tax	Patient Days/ysage	1,340,098	35	184,769	5,516	661	7
8	35	Rent-Equip & Vehicle	Patient Days	1,340,098	35	1,319,497	5,516	5,431	8
9	32	Interest	Patient Days/usage	1,340,098	35	2,398,912	5,516	12,224	9
10	1	Dietary Salary	Patient Days	1,340,098	35	135,080	135,080	556	10
11	3	Housekeeping Salary	Patient Days	1,340,098	35	151,028	151,028	622	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,340,098	35	167,731	5,516	690	12
13	10	Nurs & Med Records Salary	Patient Days/usage	1,340,098	35	1,186,643	1,186,643	4,434	13
14	15	Employee Benefits -Health Care	Patient Days	1,340,098	35	157,190	5,516	647	14
15	17	Administrative Salary	Patient Days/usage	1,340,098	35	3,283,025	3,283,025	12,081	15
16	27	Employee Benefits - Admin	Patient Days	1,340,098	35	1,345,837	5,516	5,540	16
17	19	Professional fees	Patient Days	1,340,098	35	1,018,709	751,716	4,193	17
18	21	Gen'I & Admin	Patient Days	1,340,098	35	6,837,958	6,125,097	28,146	18
19	6	Repair & Maint.	Patient Days	1,340,098	35	1,458,765	980,107	6,004	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 20,606,226	\$ 12,612,696	\$ 93,394	25

Facility Name &amp; ID Number

Alden Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

## 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	Name of Lender	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	Mortgage	\$4,317.00	9/01/12	\$ 1,212,967	\$ 1,205,784	12/31/2047	2.5000	\$ 7,738	1						
2		Cambridge		x	Operating Loss Loan	\$2,122.29	6/02	339,267	Paid off	9/37	6.8300	14,791	2						
3		Cambridge		x	Mortgage	\$4,506.29	9/03	873,700	Paid off	8/43	5.5000	31,264	3						
4		Early retirement of debt		x	Mortgage							8,038	4						
5		Amortization-Fin/Refin Fee		x	Financing							15,139	5						
		<b>Working Capital</b>																	
6		Related party-AMS		x	Working Capital							12,224	6						
7		Related party-FECII		x	Working Capital							3	7						
8		Insurance Interest (GL 7053)		x	Medical Malpractice							232	8						
9		<b>TOTAL Facility Related</b>				\$10,945.58		\$ 2,425,934	\$ 1,205,784			\$ 89,429	9						
		<b>B. Non-Facility Related*</b>																	
10		Interest Income		x	Replacement Reserve							(16)	10						
11													11						
12													12						
13													13						
14		<b>TOTAL Non-Facility Related</b>						\$	\$			(16)	14						
15		<b>TOTALS (line 9+line14)</b>						\$ 2,425,934	\$ 1,205,784			\$ 89,413	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,687 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

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2011 report.		\$	17,149	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.)		\$	18,248	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	1,100	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	16,733	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	17,833	7	
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax		\$	665
		Total Real Estate Tax Expense, Sch V, Line 33		\$	18,498
Real Estate Tax Bill for Calendar Year:	2007	15,016	8		
	2008	15,707	9		
	2009	16,202	10		
	2010	16,663	11		
	2011	18,248	12		
<b>the current year accrual is based on an estimated 3% increase of the prior year tax</b>					
				<b>FOR BHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 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.**

## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Trails, Inc. COUNTY DuPage  
 FACILITY IDPH LICENSE NUMBER 42051  
 CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll  
 TELEPHONE 773-286-3883 FAX #: 773-286-8038

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(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. <u>See attached (Supplement)</u>	<u>Related party-Alden Management</u>	\$ <u>303,210.00</u>	\$ <u>661.00</u>
2. <u>See attached (Supplement)</u>	<u>Related party-Forum Ext. Care</u>	\$ <u>37,853.00</u>	\$ <u>4.00</u>
3. <u>02-23-301-016</u>	<u>Nursing Home Facility</u>	\$ <u>18,248.18</u>	\$ <u>18,248.18</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>359,311.18</u></u>	\$ <u><u>18,913.18</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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.**

Facility Name & ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 6,610 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).

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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>Nursing facility</u>	<u>38,474</u>	<u>1995</u>	<u>\$ 147,679</u>	1
2					2
3	<b>TOTALS</b>	<b>38,474</b>		<b>\$ 147,679</b>	<b>3</b>

**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	16	1997	1997	934,861	23,372	40	23,372		339,511	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	2 TV Modules		1999	1,775		5			1,775	9
10	Sprinkler System		1999	1,690	113	15	113		1,560	10
11	Replace heads-Irrigation system		1998	1,653	110	15	110		1,606	11
12	Carpentry, Ceramic,Quarry, Corain tops		2003	14,274	714	20	714	0	7,140	12
13	Panels		2003	5,175		5			5,175	13
14	Replaced Floor Tile		2006	2,730	273	10	273		1,865	14
15	New Sidewalk Ramp Railing-ABC		2008	3,722	248	15	248		1,333	15
16	Install Automatic Doors-ABC		2008	5,909	591	10	591		2,561	16
17	Sealcoat Parking Lot - ABC		2009	4,981	623	8	623		2,180	17
18										18
19	Kitchen work(cabinetry,floor repair,wall repair & paint) - ABC		2011	11,117	556	20	556		973	19
20	Asphalt removal & replacement sealcoating marking restripe-ROSPAV		2011	6,637	830	8	830		1,037	20
21	Valve maintenance/install stocked spare head cabinet - USFIRE		2011	2,500	500	5	500		500	21
22										22
23	ABC - Repair pump/plugged w/ debris, not working		2012	4,819	442	10	442		442	23
24	ABC - Repair septic tank pumps		2012	6,829	57	10	57		57	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,008,672	\$ 28,429		\$ 28,429	\$ 0	\$ 367,715	1
2	Forum Prof Ctr: Remodeling	1979	15,057		20			15,057	2
3	Forum Prof Ctr: Build Improv - multiple	1980	29,324		15			29,324	3
4	Forum Prof Ctr: Tennant Improv	1986	925		13			925	4
5	Forum Prof Ctr: AMS remodel	1990	6,289		10			6,289	5
6	Forum Prof Ctr: Roof	1994	3,317		16			3,317	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,170	73	16	73		1,170	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,848	14	10	14		1,816	8
9	Forum Prof Ctr: Remodel/electrical	2001	720	26	7	26		694	9
10	Forum Prof Ctr: bathroom remodel	2002	637	45	5	45		637	10
11	Forum Prof Ctr: remodel suites/etc.	2003	818	81	9	81		818	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,519	101	7	101		2,291	12
13	Forum Prof Ctr: Suite renovation	2005	509	(12)	10	(12)		590	13
14	Forum Prof Ctr: Superior installations, etc.	2006	121		4			121	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	489	59	7	59		389	15
16	Forum Prof Ctr: Park, Lot/glass/maj hvac	2008	420	51	7	51		284	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	854	82	7	82		264	17
18	Forum Prof Ctr: Building Renovations	2010	1,455	295	7	295		676	18
19	Forum Prof Ctr: Building Renovations	2011	6,379	648	7	648		802	19
20	Forum Prof Ctr: Building Renovations	2012	278	38	7	38		38	20
21	Alden Mgt Servs: Remodel suites	1993	6,764		7			6,764	21
22	Alden Mgt Servs: Remodel suites	2002	282		7			282	22
23	Alden Mgt Servs: Remodel suites	2003	6,115		7			6,115	23
24									24
25									25
26									26
27	Adj for ABC related party profit	2008	(55)	(6)		(6)		(24)	27
28	Adj for ABC related party profit	2009	(66)	(8)		(8)		(28)	28
29	Adj for ABC related party profit	2011	86	6		6		9	29
30	Adj for ABC related party profit	2012	719	31		31		31	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,095,647	\$ 29,953		\$ 29,953	\$ 0	\$ 446,367	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	\$ 161,830	\$ 19,307	\$ 19,307	\$	various	\$ 115,046	71
72	Current Year Purchases	6,055	543	543		various	543	72
73	Fully Depreciated Assets	91,092	501	501		various	91,092	73
74								74
75	TOTALS	\$ 258,977	\$ 20,351	\$ 20,351	\$		\$ 206,681	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	Related party-AMS	Various	98-'02	\$ 3,911	\$	\$	\$	3	\$ 3,911	76
77	Bus	2001 - Bus Midwest Transit	2001	16,646				5	16,646	77
78	Auto-maj repair-patient									78
79	transport	Bus	2000 & 2003	6,558				3	6,558	79
80	TOTALS			\$ 27,115	\$	\$	\$		\$ 27,115	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)	\$ 1,529,418	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,304	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,304	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 680,163	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	Generators	\$ 18,320	92
93			93
94			94
95		\$ 18,320	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 Trails

# 0042051

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning 12/02/1996

Ending 11/30/2036

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

Fiscal Year Ending                      Annual Rent

12. 12/31/13                      \$ varies

13. 12/31/14                      \$ varies

14. 12/31/15                      \$ varies

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: \$ 8,364 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>227.00</u>	\$ <u>2,724</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>227.00</u>	\$ <u>2,724</u>	21

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

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

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	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							2,174					2,174		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify): <u>Exceptional Care</u>	39-1,39-3															12
13	Other (specify): <u>See Pg 16A</u>									6,969					6,969		13
14	<b>TOTAL</b>			\$				\$		\$ 9,143				\$ 9,143			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.

**Trails  
2012**

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	\$2,730.97
2.	ST	39-3	To Col 5	2,365.48
3.				
4.	PT	39-3	To Col 5	6,448.90
5.				<u>11,545.35</u>
6.				
7.				
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type facilities			<u>(11,545.35)</u>
				<u><b>0.00</b></u>
	Pharmacy Supplies per GL			1,701.56
	Manual Input from Related Party- Forum Drugs			472.22
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	<u>2,173.78</u>
10.				
11.				
12.	Exceptional Care-Salaries:	See pg 16A	To Col. 3	0.00
12.	Exceptional Care-Supplies:	See pg 16A	To Col. 6	
	Total Exceptional Care (Line 12, Col 8)			<u>0.00</u>

13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT	To Col 5		0.00
Other			16,421.69
Manual Input: Related Party - Prism			(9,369.00)
Manual Input: Related Party FECII - I.V.			-
Manual Input: Related Party FECII - Wound Care Radiology(X-Rays) Therapy Oxygen, from reclass worksheet (Pg 4A) Rounding			(83.59)
13. Col 6: Supplies Total	To Col 6	-----	6,969.10
13. Total Line 13, Column 8		-----	6,969.10
14. Total		=====	9,142.88

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

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

		1	2	
		Operating	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 250 )	309,421	309,421	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,754	6
7	Other Prepaid Expenses	1,893	1,893	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 311,314	\$ 317,068	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	41,444	58,559	15
16	Equipment, at Historical Cost	79,622	242,405	16
17	Accumulated Depreciation (book methods)	(88,520)	(528,059)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		39,238	21
22	Other Long-Term Assets (spec Refinancing fees)		37,644	22
23	Other(specify): Due from affiliates	721,477	936,205	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 754,023	\$ 1,864,342	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,065,337	\$ 2,181,410	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 165,196	\$ 157,433	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		21,864	29
30	Accrued Salaries Payable	55,257	55,257	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,142	8,142	31
32	Accrued Real Estate Taxes(Sch.IX-B)		18,798	32
33	Accrued Interest Payable	1,143	2,516	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Accr Exp,Due HFS,SalesTax,Etc.	4,158	4,158	36
37	Due to affiliates	46,969	46,969	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 280,865	\$ 315,137	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,185,721	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	Due to affiliates			43
44	S/holder loans, others			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,185,721	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 280,865	\$ 1,500,858	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 784,472	\$ 680,553	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,065,337	\$ 2,181,410	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 918,757	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded	(86,600)	3
4	after prior year report submitted:		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 832,157	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(47,685)	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)	\$ (47,685)	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)	\$ 784,472	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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,145,431	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,145,431	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***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Day Training Income</u>	239,964	28
28a	<u>Gain on Sale of Assets</u>	1,301	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 241,265	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,386,696	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	253,163	31
32	Health Care	441,934	32
33	General Administration	261,657	33
<b>B. Capital Expense</b>			
34	Ownership	129,355	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	276,774	35
36	Provider Participation Fee	71,498	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,434,381	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(47,685)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (47,685)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,145,431	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,145,431	49

\* 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 Trails

# 0042051

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	1,057	1,152	35,975	31.23	3
4	Licensed Practical Nurses	1,913	2,068	55,343	26.76	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	480	480	9,806	20.43	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	65	71	1,542	21.72	13
14	Head Cook	4,380	4,380	56,593	12.92	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	130	130	3,257	25.05	17
18	Housekeepers	1,433	1,507	20,690	13.73	18
19	Laundry					19
20	Administrator	500	500	13,826	27.65	20
21	Assistant Administrator	78	78	2,524	32.36	21
22	Other Administrative	52	52	1,549	29.79	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	40	40	390	9.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	22,935	24,554	291,436	11.87	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Fac Mgr, Tran Sp</u>	1,835	1,942	33,664	17.33	33
34	TOTAL (lines 1 - 33)	34,898	36,954	\$ 526,595 *	\$ 14.25	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	100/month	\$ 1,200	1-3	35
36	Medical Director	296/month	3,550	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	32/month	384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1,860/month	22,324	11-3	44
45	Social Service Consultant	47/month	560	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,018		49

C. CONTRACT NURSES

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DINUZZO, JOSEPHINE G	Administrator	0	\$ 13,826	Workers' Compensation Insurance	\$ 19,474	IDPH License Fee	\$	
HARRIS, YVONNE	Assistant Admin.	0	2,524	Unemployment Compensation Insurance	7,903	Advertising: Employee Recruitment	73	
		0		FICA Taxes	41,302	Health Care Worker Background Check		
		0		Employee Health Insurance	14,063	(Indicate # of checks performed 10)	100	
		0		Employee Meals	6,975	Patient Background Checks		
		0		Illinois Municipal Retirement Fund (IMRF)*		IHCA dues less PAC fees	618	
		0		Dental Insurance	33	Surety Bond/Collaborative Healthcare	300	
				Life Insurance	362	Allscripts/Sec of State/Annual Report	284	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 16,350</b>	Employee Relations	26	Related party-Bloomington	32	
(List each licensed administrator separately.)				Misc Payroll	259	Related party-AMS	281	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>				Related party-AMS	97
(Attach a copy of any management service agreement)							Seminar Expense	
<b>C. Professional Services</b>				<b>TOTAL</b>			<b>TOTAL</b>	
Vendor/Payee	Type		Amount			\$	(agree to Sch. V, line 24, col. 8)	\$
Alden Management Servs.	Consulting		\$ 57,272					386
Baker Tilly, LLP	Accounting fees		1,457					
Midcap	Accounting fees		209					
BDO Seidman	Accounting fees		945					
AMS (Eliminated)	Allocated Legal Fees		18,900					
Midcap	Legal Fees		133					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 78,916</b>					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting	\$ 3,848	3	\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$	\$	\$	\$
2												
3												
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18												
19												
20	TOTALS	\$ 3,848		\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$	\$	\$	\$

Facility Name &amp; ID Number Alden Trails

# 0042051

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

## 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
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,965 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. \$ 71,498  
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. \$ 6,975 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.