

		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.

I. IDPH License ID Number: <u>0050146</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Alden Estates of Skokie, Inc.</u>		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.																																																	
Address: <u>4660 Old Orchard Rd</u> <u>Skokie</u> <u>60076</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Cook</u>																																																			
Telephone Number: <u>(847)676-4800</u> Fax # <u>(847)676-4860</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>01/09/09</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☒</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☒	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other	_____			
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		☐	Trust	_____																																															
		☐	Other	_____																																															
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: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>Joan Carl</u>																																																	
		(Title) <u>Vice-President</u>																																																	
		(Signed) _____ (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) _____																																																	
		(Firm Name & Address) _____																																																	
		(Telephone) <u>()</u> Fax # <u>()</u>																																																	
		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																																																	

Facility Name & ID Number Alden Estates of Skokie, Inc.

0050146 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	56	Skilled (SNF)	56	20,440	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	56	TOTALS	56	20,440	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		936	2,331	3,267	8
9	SNF/PED					9
10	ICF	541	136		677	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	541	1,072	2,331	3,944	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 19.30%

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 x

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

I. On what date did you start providing long term care at this location? Date started 1/8/09

J. Was the facility purchased or leased after January 1, 1978? YES x Date 1/8/09 NO

K. Was the facility certified for Medicare during the reporting year? YES x NO If YES, enter number of beds certified 56 and days of care provided 2,331

Medicare Intermediary Highmark

IV. ACCOUNTING BASIS

ACCRAUAL x MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES x 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 Estates of Skokie, Inc. # 0050146 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	175,251	31,765	15,200	222,216	4,019	226,235	(6,739)	219,496			1
2	Food Purchase		113,870		113,870	(11,126)	102,744	(1,319)	101,425			2
3	Housekeeping	36,616	18,006		54,622	3,574	58,196	649	58,845			3
4	Laundry	22,910	15,127	22	38,059		38,059		38,059			4
5	Heat and Other Utilities			72,776	72,776		72,776	(211)	72,565			5
6	Maintenance	42,308	3,306	147,447	193,061		193,061	4,818	197,879			6
7	Other (specify):* Related party			244	244		244	848	1,092			7
8	TOTAL General Services	277,085	182,074	235,689	694,848	(3,533)	691,315	(1,954)	689,361			8
	B. Health Care and Programs											
9	Medical Director			11,250	11,250		11,250		11,250			9
10	Nursing and Medical Records	686,899	46,846	1,443	735,188	32,270	767,458	24,419	791,877			10
10a	Therapy		3,113	7,917	11,030		11,030		11,030			10a
11	Activities	30,248	1,993	3,028	35,269		35,269		35,269			11
12	Social Services	45,944			45,944		45,944		45,944			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related party							513	513			15
16	TOTAL Health Care and Programs	763,091	51,952	23,638	838,681	32,270	870,951	24,932	895,883			16
	C. General Administration											
17	Administrative	88,118			88,118		88,118	7,905	96,023			17
18	Directors Fees											18
19	Professional Services			84,196	84,196	(30,307)	53,889	(39,964)	13,925			19
20	Dues, Fees, Subscriptions & Promotions			147,737	147,737		147,737	(139,550)	8,187			20
21	Clerical & General Office Expenses	66,546	28,696	89,667	184,909	795	185,704	5,443	191,147			21
22	Employee Benefits & Payroll Taxes			192,570	192,570	775	193,345		193,345			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,656	3,656		3,656	219	3,875			24
25	Other Admin. Staff Transportation			5,089	5,089		5,089	1,370	6,459			25
26	Insurance-Prop.Liab.Malpractice			59,675	59,675		59,675	4,983	64,658			26
27	Other (specify):* Related party			(29,043)	(29,043)		(29,043)	34,455	5,412			27
28	TOTAL General Administration	154,664	28,696	553,547	736,907	(28,737)	708,170	(125,139)	583,031			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,194,840	262,722	812,874	2,270,436		2,270,436	(102,161)	2,168,275			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.

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			15,019	15,019		15,019	245,701	260,720			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			778	778		778	352,805	353,583			32
33	Real Estate Taxes			115,833	115,833	(115,833)		116,430	116,430			33
34	Rent-Facility & Grounds			218,378	218,378	115,833	334,211	(334,211)				34
35	Rent-Equipment & Vehicles			12,010	12,010		12,010	3,156	15,166			35
36	Other (specify):*							21,022	21,022			36
37	TOTAL Ownership			362,018	362,018		362,018	404,903	766,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		163,587	383,377	546,964		546,964	71,602	618,566			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		882		882		882	(882)				41
42	Provider Participation Fee			30,660	30,660		30,660		30,660			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		164,469	414,037	578,506		578,506	70,720	649,226			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,194,840	427,191	1,588,929	3,210,960		3,210,960	373,462	3,584,422			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		(11,126.00)	Employee Meals
	22	11,126.00	Employee Meals
22		(10,351.00)	Uniforms
	10	2,091.00	Uniforms
	1	4,019.00	Uniforms
	3	3,574.00	Uniforms
	4	-	Uniforms
	6	-	Uniforms
	11	-	Uniforms
	21	667.00	Uniforms
10			Oxygen - to appropriate cost center
	39		Oxygen - to appropriate cost center
33		(115,833.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	115,833.00	Rent - Real Estate Tax on associated landowner (Pg 6)
19			Reclass from Professional Fees to Real Estate tax
	33		Reclass from Professional Fees to Real Estate tax
21			Vendor Settlements
			Vendor Settlements (may effect more than one line)
<u>Others, if any:</u>			
19		(30,179.00)	Clinical Coordinators (Pathway Billing)
	10	30,179.00	Clinical Coordinators (Pathway Billing)
19		(128.00)	MediFax/MedCom
	21	128.00	MediFax/MedCom
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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(2,791)	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	(2,885)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,501)	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	(1,575)	21		17
18	Fines and Penalties				18
19	Entertainment	(9,407)	20		19
20	Contributions	(5,286)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(422)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	29,042	27		24
25	Fund Raising, Advertising and Promotional	(68,877)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(150)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,852)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	435,412	Various	34
35	Other- Attach Schedule	1,902	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 437,314		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 373,462		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 Yes	2 No	3 Amount	4 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

ID#

0050146

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (791)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(5,761)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	3,936	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	40,210	6	4
5	Reconcile depreciation expense	(1)	30	5
6	Elim ABC Deprec Exp from Pg 12 series -	6	30	6
7	Valet Cost	(32,825)	21	7
8	Late Fees on Utilities	(447)	5	8
9	Gift Shop Expenses	(882)	41	9
10	Misc Income - Record copies	(20)	21	10
11	Misc Income - Food rebate	(96)	2	11
12	Back out 30% of PAC Fees IHCA	(927)	20	12
13	Deming Fees	(50)	24	13
14	Real Estate Tax Adj	(10)	33	14
15	Skokie Chamber Annual Dues Back out	(440)	20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,902		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Estates of Skokie, Inc. # 0050146 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	437	(7,176)	0	0	0	0	0	0	0	(6,739)	1
2	Food Purchase	(1,597)	0	0	278	0	0	0	0	0	0	0	(1,319)	2
3	Housekeeping	0	0	649	0	0	0	0	0	0	0	0	649	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(447)	0	236	0	0	0	0	0	0	0	0	(211)	5
6	Maintenance	41,355	0	(36,675)	0	0	0	138	0	0	0	0	4,818	6
7	Other (specify):*	0	0	623	225	0	0	0	0	0	0	0	848	7
8	TOTAL General Services	39,311	0	(34,730)	(6,673)	0	0	138	0	0	0	0	(1,954)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	23,626	35	758	0	0	0	0	0	0	24,419	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	513	0	0	0	0	0	0	0	0	513	15
16	TOTAL Health Care and Programs	0	0	24,139	35	758	0	0	0	0	0	0	24,932	16
	C. General Administration													
17	Administrative	0	0	7,905	0	0	0	0	0	0	0	0	7,905	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(422)	3,020	(42,562)	0	0	0	0	0	0	0	0	(39,964)	19
20	Fees, Subscriptions & Promotions	(85,087)	250	(54,713)	0	0	0	0	0	0	0	0	(139,550)	20
21	Clerical & General Office Expenses	(34,420)	421	21,189	5,281	12,972	0	0	0	0	0	0	5,443	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	(50)	0	269	0	0	0	0	0	0	0	0	219	24
25	Other Admin. Staff Transportation	0	0	1,370	0	0	0	0	0	0	0	0	1,370	25
26	Insurance-Prop.Liab.Malpractice	0	4,971	12	0	0	0	0	0	0	0	0	4,983	26
27	Other (specify):*	29,042	0	4,116	564	733	0	0	0	0	0	0	34,455	27
28	TOTAL General Administration	(90,937)	8,662	(62,414)	5,845	13,705	0	0	0	0	0	0	(125,139)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,626)	8,662	(73,005)	(793)	14,463	0	138	0	0	0	0	(102,161)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Estates of Skokie, Inc. # 0050146 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,547)	244,061	8,187	0	0	0	0	0	0	0	0	245,701	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,885)	354,700	564	0	426	0	0	0	0	0	0	352,805	32
33	Real Estate Taxes	(10)	115,833	423	0	184	0	0	0	0	0	0	116,430	33
34	Rent-Facility & Grounds	0	(334,211)	0	0	0	0	0	0	0	0	0	(334,211)	34
35	Rent-Equipment & Vehicles	0	0	3,156	0	0	0	0	0	0	0	0	3,156	35
36	Other (specify):*	0	21,022	0	0	0	0	0	0	0	0	0	21,022	36
37	TOTAL Ownership	(9,442)	401,405	12,330	0	610	0	0	0	0	0	0	404,903	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	(4,921)	(36,073)	112,596	0	0	0	0	0	71,602	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(882)	0	0	0	0	0	0	0	0	0	0	(882)	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	(882)	0	0	(4,921)	(36,073)	112,596	0	0	0	0	0	70,720	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(61,950)	410,067	(60,675)	(5,714)	(21,000)	112,596	138	0	0	0	0	373,462	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
		See PG6-Supp		See PG6-Supp		
The Alden Group, Ltd.	100					

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	\$ 334,211	Alden Estates of Skokie, LLC		\$	\$ (334,211)	1
2	V	32	Interest Income Repl Reserve	9	Alden Estates of Skokie, LLC			(9)	2
3	V	19	Professional Fees		Alden Estates of Skokie, LLC		3,020	3,020	3
4	V	21	Licenses and Inspections		Alden Estates of Skokie, LLC		47	47	4
5	V	20	Dues and Fees		Alden Estates of Skokie, LLC		250	250	5
6	V	21	Misc costs/Office equip.		Alden Estates of Skokie, LLC		374	374	6
7	V	33	Real Estate Tax Expense		Alden Estates of Skokie, LLC		115,833	115,833	7
8	V	26	General Insurance Expense		Alden Estates of Skokie, LLC		4,971	4,971	8
9	V	36	Mortgage Insurance Premium		Alden Estates of Skokie, LLC		21,022	21,022	9
10	V	32	Interest on Mortgage		Alden Estates of Skokie, LLC		349,034	349,034	10
11	V	30	Depreciation		Alden Estates of Skokie, LLC		244,061	244,061	11
12	V	32	Amortization		Alden Estates of Skokie, LLC		5,675	5,675	12
13	V								13
14	Total			\$ 334,220			\$ 744,287	\$ * 410,067	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Alden Management Services, Inc.	0.00%	\$ 236	\$ 236	15
16	V	24	Travel & Seminar		Alden Management Services, Inc.		269	269	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,370	1,370	17
18	V	26	Insurance		Alden Management Services, Inc.		12	12	18
19	V	20	Dues & Subscriptions	54,882	Alden Management Services, Inc.		169	(54,713)	19
20	V	30	Depreciation		Alden Management Services, Inc.		8,187	8,187	20
21	V	33	Real Estate Taxes		Alden Management Services, Inc.		423	423	21
22	V	35	Rent - Equipment & Vihicles		Alden Management Services, Inc.		3,156	3,156	22
23	V	32	Interest		Alden Management Services, Inc.		564	564	23
24	V	1	Dietary		Alden Management Services, Inc.		437	437	24
25	V	3	Houskeeping		Alden Management Services, Inc.		649	649	25
26	V	7	Employee Benefits - Gen'l Services		Alden Management Services, Inc.		623	623	26
27	V	10	Nursing & Medical Records Salaries		Alden Management Services, Inc.		23,626	23,626	27
28	V	15	Employee Benefits - Health Care		Alden Management Services, Inc.		513	513	28
29	V	17	Administrative Salary		Alden Management Services, Inc.		7,905	7,905	29
30	V	27	Employee Benefits - Admin		Alden Management Services, Inc.		4,116	4,116	30
31	V	19	Professional Fees	46,000	Alden Management Services, Inc.		3,438	(42,562)	31
32	V	21	General & Adminstrative		Alden Management Services, Inc.		21,189	21,189	32
33	V	6	Repairs & Maintenance	40,703	Alden Management Services, Inc.		4,028	(36,675)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 141,585			\$ 80,910	\$ * (60,675)	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	\$ 15,200	Prism Health Care Services, Inc.	0.00%	\$ 253	\$ (14,947)	15
16	V	1	Dietary Salary		Prism Health Care Services, Inc.		7,771	7,771	16
17	V	2	Tube Feeding	100	Prism Health Care Services, Inc.		378	278	17
18	V	10	Equipment Rental	6,659	Prism Health Care Services, Inc.		6,694	35	18
19	V	39	Ancillary Supplies	7,373	Prism Health Care Services, Inc.		2,452	(4,921)	19
20	V	21	Gen'l & Admin Salary		Prism Health Care Services, Inc.		3,378	3,378	20
21	V	27	Employee Benefits		Prism Health Care Services, Inc.		564	564	21
22	V	7	Employee Benefits		Prism Health Care Services, Inc.		225	225	22
23	V	21	General & Administrative		Prism Health Care Services, Inc.		1,903	1,903	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			\$ 29,332			\$ 23,618	\$ * (5,714)	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	\$ 78,641	Forum Extended Care Services II, Inc.	0.00%	\$ 108,983	\$ 30,342	15
16	V	39	I.V.	74,546	Forum Extended Care Services II, Inc.		8,763	(65,783)	16
17	V	39	Wound Care	3,026	Forum Extended Care Services II, Inc.		2,394	(632)	17
18	V	10	House Stock	3,333	Forum Extended Care Services II, Inc.		3,084	(249)	18
19	V	10	Pharmacy Consultant	1,344	Forum Extended Care Services II, Inc.		2,351	1,007	19
20	V	27	Employee Vaccination	1,357	Forum Extended Care Services II, Inc.		1,073	(284)	20
21	V	27	Employee Benefits: G & A		Forum Extended Care Services II, Inc.		1,017	1,017	21
22	V	21	Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		8,172	8,172	22
23	V	21	Gen'l & Admin.		Forum Extended Care Services II, Inc.		4,800	4,800	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		426	426	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		184	184	25
26	V	30	Depreciation		Forum Extended Care Services II, Inc.				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			\$ 162,247			\$ 141,247	\$ * (21,000)	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	Therapy	\$ 334,738	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 447,334	\$ 112,596	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			\$ 334,738			\$ 447,334	\$ * 112,596	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	\$ 17,731	Alden Bennett Construction Company, Inc.	0.00%	\$ 17,869	\$ 138	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			\$ 17,731			\$ 17,869	\$ * 138	39

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

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-Northmoor Rehabilitation and Health Car	Chicago	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 Water	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 Yo	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								29
30			Alden Estates of Countryside, Inc.	Jefferson, WI				30

Facility Name & ID Number Alden Estates of Skokie, Inc. # 0050146 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	184,445	0.12	0.00	Salary	\$ 555	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,434	0.12	0.00	Salary	206	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,402	0.12	0.00	Salary	118	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	\$ 879		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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty		x	Mortgage	\$49,339.00	7/11	\$ 9,024,300	\$ 9,001,105	6/51	5.9500	\$ 349,034	1
2												2
3												3
4	Amortization		x	Refinancing							5,675	4
5	Insurance Interest		x	Medical Malpractice							778	5
	Working Capital											
6	Related party-AMS		x	Working Capital							564	6
7	Related party-FECII		x	Working Capital							426	7
8												8
9	TOTAL Facility Related				\$49,339.00		\$ 9,024,300	\$ 9,001,105			\$ 356,477	9
	B. Non-Facility Related*											
10	Interest Income		x	Replacement Reserve							(9)	10
11	Interest Income		x	Resident Interest							(2,885)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (2,894)	14
15	TOTALS (line 9+line14)						\$ 9,024,300	\$ 9,001,105			\$ 353,583	15

16)

Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ 21,022

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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	87,600	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.)			\$	163,419	2
3. Under or (over) accrual (line 2 minus line 1).			\$	75,819	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	40,004	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.			\$	115,823	7
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax	\$	607	
Real Estate Tax Bill for Calendar Year:			\$	116,430	
2006		8	FOR BHF USE ONLY		
2007	106,161	9	13	FROM R. E. TAX STATEMENT FOR 2010 \$	13
2008	105,897	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
2009	85,090	11	15	LESS REFUND FROM LINE 6 \$	15
2010	163,419	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
The current year accrual is based on an estimated 3% increase of the prior year tax.					

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 Estates of Skokie, Inc.

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0050146

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>See attached supplement</u>	<u>Related Party-Alden Management Ser</u>	\$ <u>300,377.00</u>	\$ <u>423.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	\$ <u>42,023.00</u>	\$ <u>184.00</u>
3. <u>10-10-103-024</u>	<u>Nursing Home Facility</u>	\$ <u>162,714.01</u>	\$ <u>162,714.01</u>
4. <u>10-10-103-029</u>	<u>Nursing Home Facility</u>	\$ <u>705.24</u>	\$ <u>705.24</u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>505,819.25</u>	\$ <u>164,026.25</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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

19,000

B. General Construction Type:

Exterior

Brick

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).

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	56 Bed Facility		2009	\$ 229,315	1
2					2
3	TOTALS			\$ 229,315	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	56		2009		\$ 1,246,896	\$ 31,574	39	\$ 31,574	\$	\$ 94,723
5				2011	6,157,997	105,265	39	105,265		105,265
6										
7										
8										
	Improvement Type**									
9	GT Mechanical-Actuator, Transformer, Belts, & Filters (HVAC)			2009	2,838	567	5	567		1,465
10	Long Elevator - Elevator Pump Motor			2009	3,139	628	5	628		1,361
11										
12	Gutters and Downspouts installation-ABC			2011	8,173	204	10	204		204
13	Sprinkler system installation-ABC			2011	5,662	57	25	57		57
14	Heating system for roof-ABC			2011	48,105	401	10	401		401
15	Heaters:Installation of infared heaters in driveway-ABC			2011	10,672		10			
16	Bathroom plumbing repair-ABC			2011	5,107	170	5	170		170
17	Design & permit of alternate water service-JACHEF			2011	2,928	195	10	195		195
18	Design & permit of alternate water service-JACHEF			2011	2,867	167	10	167		167
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Estates of Skokie, Inc.

0050146

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,494,384	\$ 139,228		\$ 139,228	\$	\$ 204,008	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	Adj for ABC related party profit	2011	605	6		6		6	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,573,452	\$ 140,192		\$ 140,192	\$	\$ 274,658	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	\$ 85,578	\$ 17,041	\$ 17,041	\$		\$ 41,850	71
72	Current Year Purchases	817,026	103,487	103,487			103,487	72
73	Fully Depreciated Assets	58,066					58,066	73
74								74
75	TOTALS	\$ 960,670	\$ 120,528	\$ 120,528	\$		\$ 203,403	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-MAS	Various	98-02	\$ 4,026	\$	\$	\$	3	\$ 4,026	76
77										77
78										78
79										79
80	TOTALS			\$ 4,026	\$	\$	\$		\$ 4,026	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 8,767,463	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 260,720	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,720	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 482,087	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Related party cost is backed out
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
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: \$11,418Description: 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	related party- Pg 6A	various	\$178.67	\$2,144	17
18					18
19	Auto lease GL 6890	various	0.00		19
20					20
21	TOTAL		\$178.67	\$2,144	21

10. Effective dates of current rental agreement:

Beginning01/01/09

Ending01/01/19

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$varies
13.	/2013	\$varies
14.	/2014	\$varies

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nursing on site

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

- (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.)										
		1	2	3	4	5	6	7	8	
	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	\$		\$ 99,912	\$		\$ 99,912	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,466			10,466	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			264,533			264,533	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				108,983		108,983	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					112,596	22,076		134,672	13
14	TOTAL			\$		\$ 487,506	\$ 131,059		\$ 618,566	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.

				Page 16
				Col 5: PT,OT, & ST
				Col 6: Supplies
XIV. Special Services (Direct Cost)				
Line	Service	Col. 1: Ref. No.	To Pg 16: Col. No.	
1.	OT	39-3	To Col 5	\$99,911.63
2.	ST	39-3	To Col 5	10,465.79
3.				
4.	PT	39-3	To Col 5	264,532.80
5.				
6.				
7.				
8.				
	Pharmacy Supplies per GL			78,641.16
	Manual Input from Related Party- Forum Drugs			30,342.00
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	108,983.16
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	112,596.00
	Other			93,412.03
	Manual Input: Related Party - Prism			(4,921.00)
	Manual Input: Related Party FECII - I.V.			(65,783.00)
	Manual Input: Related Party FECII - Wound Care			(632.00)
	Oxygen, from reclass worksheet (Pg 4A)			
	Rounding			0.10
13.	Col 6: Supplies Total		To Col 6	22,076.13
13.	Total Line 13, Column 8			134,672.13
14.	Total			618,565.51

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 32,712	\$ 57,586	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	319,081	319,081	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,716	28,374	6
7	Other Prepaid Expenses	2,188	65,928	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties	7,049	98,713	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 382,746	\$ 569,682	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		373,915	13
14	Buildings, at Historical Cost		7,395,188	14
15	Leasehold Improvements, at Historical Cost	90,599	869,373	15
16	Equipment, at Historical Cost	147,733	147,733	16
17	Accumulated Depreciation (book methods)	(22,851)	(350,350)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		39,106	21
22	Other Long-Term Assets (spe Repl resrv, CIP, S/holders			22
23	Other(specify): Due from affiliates		366,532	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 215,481	\$ 8,841,498	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 598,227	\$ 9,411,180	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 173,464	\$ 196,332	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,877	35,877	28
29	Short-Term Notes Payable		58,066	29
30	Accrued Salaries Payable	133,967	133,967	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,956	32,956	31
32	Accrued Real Estate Taxes(Sch.IX-B)		40,004	32
33	Accrued Interest Payable		44,630	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp,Due HFS,SalesTax,Etc.	11,199	18,462	36
37	Due to affiliates	681,789	681,789	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,069,252	\$ 1,242,083	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,943,039	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliates	2,008,790	1,933,475	43
44	S/holder loans, others			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,008,790	\$ 10,876,514	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,078,042	\$ 12,118,597	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,479,815)	\$ (2,707,417)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 598,227	\$ 9,411,180	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,126,093)	1
2	Restatements (describe):		2
3			3
4		2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,126,091)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,353,724)	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)	\$ (1,353,724)	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)	\$ (2,479,815)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Estates of Skokie, Inc.

0050146

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.

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,841,826	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,841,826	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,433	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,433	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	181	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	2,405	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,340	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,976	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,885	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,885	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Pg 19A	116	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 116	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,857,236	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	694,848	31
32	Health Care	838,681	32
33	General Administration	736,907	33
	B. Capital Expense		
34	Ownership	362,018	34
	C. Ancillary Expense		
35	Special Cost Centers	547,846	35
36	Provider Participation Fee	30,660	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,210,960	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,353,724)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,353,724)	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 Estates of Skokie, Inc.	# 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 related to medical record copies	\$ 20
Misc Income related to food rebate	96
Line 28 Total:	<u>116</u>

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	1,760	1,760	\$ 88,132	\$ 50.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,351	10,597	335,429	31.65	3
4	Licensed Practical Nurses	3,236	3,538	85,012	24.03	4
5	CNAs & Orderlies	14,257	14,602	164,221	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,122	3,198	30,247	9.46	10
11	Social Service Workers	2,080	2,080	45,944	22.09	11
12	Dietician					12
13	Food Service Supervisor	1,160	1,160	25,970	22.39	13
14	Head Cook	2,512	2,528	59,413	23.50	14
15	Cook Helpers/Assistants	7,854	7,900	89,869	11.38	15
16	Dishwashers					16
17	Maintenance Workers	1,680	1,680	42,308	25.18	17
18	Housekeepers	3,219	3,286	36,616	11.14	18
19	Laundry	2,226	2,338	22,910	9.80	19
20	Administrator	2,080	2,080	88,118	42.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,416	1,416	33,693	23.79	23
24	Clerical	2,949	2,972	32,853	11.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	80	80	2,827	35.34	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Unit Manager	655	655	11,278	17.22	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	60,637	61,870	\$ 1,194,840 *	\$ 19.31	34

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	1,267/mo	\$ 15,200	1-3	35
36	Medical Director	938/mo	11,250	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	112/mo	1,344	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	81/mo	969	11-3	44
45	Social Service Consultant	47/mo	560	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,323		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

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

** See instructions.

Facility Name & ID Number		Alden Estates of Skokie, Inc.		STATE OF ILLINOIS		# 0050146		Report Period Beginning:		1/1/2011		Page 21		Ending:		12/31/2011	
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			
Broadbent, Lindsay		Administrator		0		\$ 88,118		Workers' Compensation Insurance		\$ 19,947		IDPH License Fee		\$			
				0				Unemployment Compensation Insurance		27,710		Advertising: Employee Recruitment		2,576			
				0				FICA Taxes		89,912		Health Care Worker Background Check					
				0				Employee Health Insurance		34,027		(Indicate # of checks performed 144)		1,440			
				0				Employee Meals		11,126		Patient Background Checks		67			
				0				Illinois Municipal Retirement Fund (IMRF)*				Surety Bond Fees		100			
				0				Dental Insurance		27		IHCA dues less PAC fees		2,164			
				0				Life Insurance		594		Allscripts		818			
TOTAL (agree to Schedule V, line 17, col. 1)								Employee Relations & Misc. Payroll Costs		6,914		Related Party - Skokie LLC		250			
(List each licensed administrator separately.)						\$ 88,118		Employee Drug Tests		1,520		Related Part - AMS		169			
B. Administrative - Other												Less: Public Relations Expense ()					
Description						Amount						Non-allowable advertising ()					
						\$						Yellow page advertising ()					
TOTAL (agree to Schedule V, line 17, col. 3)						\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 193,345		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 8,187			
(Attach a copy of any management service agreement)																	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**									
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount			
Alden Management Services, Inc.		Consulting		\$ 10,000						\$		Out-of-State Travel		\$			
AMS (Eliminated)		Allocated Legal Fees		36,000													
Pathway (Reclassified)		Clinical Coordinators		30,179													
Medifax/EDI		Billing Service		128								In-State Travel					
Linda Roberts & Assoc., Inc.		Food & Nutrition Consultant		598								Related Party - AMS		269			
BDO Seidman/Virchow Krause		Accounting Fees		6,636								Act. Director Course		375			
Ken Fisch		Legal Fees		422								Food Safet Cert/Nat Inv Cen Conf		370			
KPMG/Ava Daley		Accounting Fees		233								Seminar Expense		592			
												Leadership Training		200			
												IHCA Convent./IL Council		1,307			
												Geriatrics/Adult Behav/Health Inf Netw		762			
												Entertainment Expense ()					
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL		\$		(agree to Sch. V, line 24, col. 8)					
(If total legal fees exceed \$5,000, attach copy of invoices.)						\$ 84,196						TOTAL		\$ 3,875			
* Attach copy of IMRF notifications																	
**See instructions.																	

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?
If YES, give association name and amount.

Yes
IHCA=\$2,164

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 2,161 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(9)

Are you presently operating under a sublease agreement?

YES No NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

x

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 30,660

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 11,126
Indicate the amount. \$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?
Attach invoices and a summary of services for all architect and appraisal fees.

No