

		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: 42051

Facility Name: Alden Trails, Inc.

Address: 273 E. Army Trails Rd Bloomingdale 60108
Number City Zip Code

County: DuPage

Telephone Number: (630)671-1990 Fax # (630)671-0540

HFS ID Number:

Date of Initial License for Current Owners: 05/19/98

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☒ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll Telephone Number: (773) 724-6622
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Joan Carl
(Title) Vice-President

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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 Trails, Inc.

42051 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		Skilled (SNF)		0	1
2		Skilled Pediatric (SNF/PED)		0	2
3		Intermediate (ICF)		0	3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)		0	5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	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	5,662			5,662	13
14	TOTALS	5,662			5,662	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.95%

D. How many bed-hold days during this year were paid by the Department? 141 (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 8/15/98

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

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

Medicare Intermediary N/A

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 Trails, Inc. # 42051 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	56,726	4,290	1,200	62,216	2,178	64,394	61	64,455			1
2	Food Purchase		46,213		46,213	(7,083)	39,130	(6,311)	32,819			2
3	Housekeeping	12,466	6,505		18,971		18,971	935	19,906			3
4	Laundry		5,348		5,348		5,348		5,348			4
5	Heat and Other Utilities			17,095	17,095		17,095	286	17,381			5
6	Maintenance	7,655		62,099	69,754		69,754	519	70,273			6
7	Other (specify):* Related party							1,056	1,056			7
8	TOTAL General Services	76,847	62,356	80,394	219,597	(4,905)	214,692	(3,454)	211,238			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	398,072	18,673	1,089	417,834	1,772	419,606	5,034	424,640			10
10a	Therapy		199		199	7,250	7,449	(4,963)	2,486			10a
11	Activities		30	22,764	22,794		22,794		22,794			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related party							736	736			15
16	TOTAL Health Care and Programs	398,072	18,902	26,853	443,827	9,022	452,849	807	453,656			16
	C. General Administration											
17	Administrative	15,605			15,605		15,605	11,349	26,954			17
18	Directors Fees											18
19	Professional Services			106,146	106,146	(37)	106,109	(94,969)	11,140			19
20	Dues, Fees, Subscriptions & Promotions			17,944	17,944		17,944	(16,488)	1,456			20
21	Clerical & General Office Expenses	39,358	2,273	11,729	53,360	37	53,397	34,605	88,002			21
22	Employee Benefits & Payroll Taxes			83,774	83,774	3,133	86,907	(44)	86,863			22
23	Inservice Training & Education											23
24	Travel and Seminar			369	369		369	386	755			24
25	Other Admin. Staff Transportation			4,085	4,085		4,085	1,966	6,051			25
26	Insurance-Prop.Liab.Malpractice			17,050	17,050		17,050	1,459	18,509			26
27	Other (specify):* Related party			5,449	5,449		5,449	844	6,293			27
28	TOTAL General Administration	54,963	2,273	246,546	303,782	3,133	306,915	(60,892)	246,023			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	529,882	83,531	353,793	967,206	7,250	974,456	(63,539)	910,917			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			3,775	3,775		3,775	42,117	45,892			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,085	23,085		23,085	50,921	74,006			32
33	Real Estate Taxes			15,432	15,432	(15,432)		21,192	21,192			33
34	Rent-Facility & Grounds			80,601	80,601	15,432	96,033	(96,033)				34
35	Rent-Equipment & Vehicles			7,157	7,157		7,157	4,530	11,687			35
36	Other (specify):* MIP							6,558	6,558			36
37	TOTAL Ownership			130,050	130,050		130,050	29,285	159,335			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,603	7,250	22,853	(7,250)	15,603	(6,672)	8,931			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,095	67,095		67,095		67,095			42
43	Other (specify):* TranSp,DayTrain	7,095		258,566	265,661		265,661		265,661			43
44	TOTAL Special Cost Centers	7,095	15,603	332,911	355,609	(7,250)	348,359	(6,672)	341,687			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	536,977	99,134	816,754	1,452,865		1,452,865	(40,926)	1,411,939			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

From Line	To Line	Amount	Description
2		(7,083.00)	Employee Meals
	22	7,083.00	Employee Meals
22		(3,950.00)	Uniforms
	10	1,772.00	Uniforms
	1	2,178.00	Uniforms
	3	-	Uniforms
	4	-	Uniforms
	6	-	Uniforms
	11	-	Uniforms
	21	-	Uniforms
10			Oxygen - to appropriate cost center
	39		Oxygen - to appropriate cost center
33		(15,432.00)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	15,432.00	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)
Others, if any:			
19		-	Clinical Coordinators (Pathway Billing)
	10	-	Clinical Coordinators (Pathway Billing)
19		(37.00)	MediFax/MedCom
	21	37.00	MediFax/MedCom
39		(7,250.00)	PT, OT, ST CPT Therapy Costs
	10A	7,250.00	PT, OT, ST CPT Therapy Costs
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				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	(83)	21		17
18	Fines and Penalties				18
19	Entertainment	(149)	20		19
20	Contributions	(420)	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	(5,449)	27		24
25	Fund Raising, Advertising and Promotional	(2,172)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,273)		\$	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)	(34,792)	Various	34
35	Other- Attach Schedule	2,139	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (32,653)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (40,926)		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

Alden Trails, Inc.

	ID#	42051
Report Period Beginning:		1/1/2011
Ending:		12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (627)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(2,860)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	2,146	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	8,764	6	4
5	Reconcile Depreciation expense	1,293	30	5
6	Elim ABC Deprec Exp from Pg 12 series -	(11)	30	6
7	Late Fees on Utilities	(52)	5	7
8	Intercompany Interest	(8,852)	32	8
9	Misc Income - Wage Service Fee	(44)	22	9
10	Back out 30% of PAC Fees IHCA	(265)	20	10
11	Prior Year Accrual Adj RE Tax	3,397	33	11
12	Back out Group MidCap Legal Fees	(415)	19	12
13	Back out Group MidCap Accounting Fees	(209)	19	13
14	Back out Deferred Maintenance	(1)	6	14
15	Bloomingtondale Chamber Dues Back out	(125)	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	Total	2,139		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Trails, Inc. # 42051 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	627	(566)	0	0	0	0	0	0	0	61	1
2	Food Purchase	0	0	0	(6,311)	0	0	0	0	0	0	0	(6,311)	2
3	Housekeeping	0	0	935	0	0	0	0	0	0	0	0	935	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(52)	0	338	0	0	0	0	0	0	0	0	286	5
6	Maintenance	10,909	0	(10,495)	0	0	0	105	0	0	0	0	519	6
7	Other (specify):*	0	0	895	161	0	0	0	0	0	0	0	1,056	7
8	TOTAL General Services	10,857	0	(7,700)	(6,716)	0	0	105	0	0	0	0	(3,454)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,856	1	177	0	0	0	0	0	0	5,034	10
10a	Therapy	0	0	0	0	0	(4,963)	0	0	0	0	0	(4,963)	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	736	0	0	0	0	0	0	0	0	736	15
16	TOTAL Health Care and Programs	0	0	5,592	1	177	(4,963)	0	0	0	0	0	807	16
	C. General Administration													
17	Administrative	0	0	11,349	0	0	0	0	0	0	0	0	11,349	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(624)	2,472	(96,817)	0	0	0	0	0	0	0	0	(94,969)	19
20	Fees, Subscriptions & Promotions	(3,131)	135	(13,492)	0	0	0	0	0	0	0	0	(16,488)	20
21	Clerical & General Office Expenses	(83)	0	30,419	3,769	500	0	0	0	0	0	0	34,605	21
22	Employee Benefits & Payroll Taxes	(44)	0	0	0	0	0	0	0	0	0	0	(44)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	386	0	0	0	0	0	0	0	0	386	24
25	Other Admin. Staff Transportation	0	0	1,966	0	0	0	0	0	0	0	0	1,966	25
26	Insurance-Prop.Liab.Malpractice	0	1,441	18	0	0	0	0	0	0	0	0	1,459	26
27	Other (specify):*	(5,449)	0	5,909	402	(18)	0	0	0	0	0	0	844	27
28	TOTAL General Administration	(9,331)	4,048	(60,262)	4,171	482	0	0	0	0	0	0	(60,892)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	1,526	4,048	(62,370)	(2,544)	659	(4,963)	105	0	0	0	0	(63,539)	29

Summary B

12/31/2011

													SUMMARY	
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)		
Depreciation	(2,205)	36,135	8,187	0	0	0	0	0	0	0	0	42,117	30	
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31	
Interest	(8,852)	52,786	6,971	0	16	0	0	0	0	0	0	50,921	32	
Real Estate Taxes	3,397	17,181	607	0	7	0	0	0	0	0	0	21,192	33	
Rent-Facility & Grounds	0	(96,033)	0	0	0	0	0	0	0	0	0	(96,033)	34	
Rent-Equipment & Vehicles	0	0	4,530	0	0	0	0	0	0	0	0	4,530	35	
Other (specify):*	0	6,558	0	0	0	0	0	0	0	0	0	6,558	36	
TOTAL Ownership	(7,660)	16,627	20,295	0	23	0	0	0	0	0	0	29,285	37	
Ancillary Expense														
E. Special Cost Centers														
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38	
Ancillary Service Centers	0	0	0	(7,686)	1,014	0	0	0	0	0	0	(6,672)	39	
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40	
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41	
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42	
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43	
TOTAL Special Cost Centers	0	0	0	(7,686)	1,014	0	0	0	0	0	0	(6,672)	44	
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,134)	20,675	(42,075)	(10,230)	1,696	(4,963)	105	0	0	0	0	(40,926)	45	

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group, Ltd.	100	See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 96,033	Alden of Bloomingdale Limited Partnership		\$	\$ (96,033)	1
2	V	32	Interest Income - RR	11	Alden of Bloomingdale Limited Partnership			(11)	2
3	V	32	Interest Income	14,011	Alden of Bloomingdale Limited Partnership			(14,011)	3
4	V	19	Accounting Fees		Alden of Bloomingdale Limited Partnership		2,472	2,472	4
5	V								5
6	V	20	Dues & Subscriptions/Licenses & Inspections		Alden of Bloomingdale Limited Partnership		135	135	6
7	V	33	Real Estate Tax Expense		Alden of Bloomingdale Limited Partnership		17,181	17,181	7
8	V	26	General Insurance Expense		Alden of Bloomingdale Limited Partnership		1,441	1,441	8
9	V	36	Mortgage Insurance Premium		Alden of Bloomingdale Limited Partnership		6,558	6,558	9
10	V	32	Interest - Other		Alden of Bloomingdale Limited Partnership		44,797	44,797	10
11	V	32	Interest - IOD		Alden of Bloomingdale Limited Partnership		21,193	21,193	11
12	V	30	Depreciation Expense		Alden of Bloomingdale Limited Partnership		36,135	36,135	12
13	V	32	Amortization Expense		Alden of Bloomingdale Limited Partnership		818	818	13
14	Total			\$ 110,055			\$ 130,730	\$ * 20,675	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%	\$ 338	\$ 338	15
16	V	24	Travel & Seminar		Alden Management Services, Inc.		386	386	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		1,966	1,966	17
18	V	26	Insurance		Alden Management Services, Inc.		18	18	18
19	V	20	Dues & Subscriptions	13,735	Alden Management Services, Inc.		243	(13,492)	19
20	V	30	Depreciation		Alden Management Services, Inc.		8,187	8,187	20
21	V	33	Real Estate Taxes		Alden Management Services, Inc.		607	607	21
22	V	35	Rent - Equipment & Vihicles		Alden Management Services, Inc.		4,530	4,530	22
23	V	32	Interest		Alden Management Services, Inc.		6,971	6,971	23
24	V	1	Dietary		Alden Management Services, Inc.		627	627	24
25	V	3	Houskeeping		Alden Management Services, Inc.		935	935	25
26	V	7	Employee Benefits - Gen'l Services		Alden Management Services, Inc.		895	895	26
27	V	10	Nursing & Medical Records Salaries		Alden Management Services, Inc.		4,856	4,856	27
28	V	15	Employee Benefits - Health Care		Alden Management Services, Inc.		736	736	28
29	V	17	Administrative Salary		Alden Management Services, Inc.		11,349	11,349	29
30	V	27	Employee Benefits - Admin		Alden Management Services, Inc.		5,909	5,909	30
31	V	19	Professional Fees	101,752	Alden Management Services, Inc.		4,935	(96,817)	31
32	V	21	General & Adminstrative		Alden Management Services, Inc.		30,419	30,419	32
33	V	6	Repairs & Maintenance	16,277	Alden Management Services, Inc.		5,782	(10,495)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 131,764			\$ 89,689	\$ * (42,075)	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 Services, Inc.	0.00%	\$ 20	\$ (1,180)	15
16	V	1	Dietary Salary		Prism Health Care Services, Inc.		614	614	16
17	V	2	Tube Feeding	7,878	Prism Health Care Services, Inc.		1,567	(6,311)	17
18	V	10	Equipment Rental	361	Prism Health Care Services, Inc.		362	1	18
19	V	39	Ancillary Supplies	11,492	Prism Health Care Services, Inc.		3,806	(7,686)	19
20	V	21	Gen'l & Admin Salary		Prism Health Care Services, Inc.		2,411	2,411	20
21	V	27	Employee Benefits		Prism Health Care Services, Inc.		402	402	21
22	V	7	Employee Benefits		Prism Health Care Services, Inc.		161	161	22
23	V	21	General & Administrative		Prism Health Care Services, Inc.		1,358	1,358	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			\$ 20,931			\$ 10,701	\$ * (10,230)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	\$ 3,151	Forum Extended Care Services II, Inc.	0.00%	\$ 4,366	\$ 1,215	15
16	V	39	Wound Care	960	Forum Extended Care Services II, Inc.		759	(201)	16
17	V	10	House Stock	1,485	Forum Extended Care Services II, Inc.		1,374	(111)	17
18	V	10	Pharmacy Consultant	384	Forum Extended Care Services II, Inc.		672	288	18
19	V	27	Employee Vaccination	282	Forum Extended Care Services II, Inc.		225	(57)	19
20	V	27	Employee Benefits: G & A		Forum Extended Care Services II, Inc.		39	39	20
21	V	21	Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		315	315	21
22	V	21	Gen'l & Admin.		Forum Extended Care Services II, Inc.		185	185	22
23	V	32	Interest		Forum Extended Care Services II, Inc.		16	16	23
24	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		7	7	24
25	V				Forum Extended Care Services II, Inc.				25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 6,262			\$ 7,958	\$ * 1,696	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	\$ 7,250	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 2,287	\$ (4,963)	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			\$ 7,250			\$ 2,287	\$ * (4,963)	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	\$13,468	Alden Bennett Construction Company, Inc.	0.00%	\$13,573	\$105	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			\$13,468			\$13,573	\$*105	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								17
18			Alden - Poplar Creek Rehabilitation and Health (	Hoffman Estates				18
19			Alden - North Shore Rehabilitation and Health C	Skokie				19
20			Alden - Des Plaines Rehabilitation and Health C	Des Plaines				20
21			Alden Estates of Evanston, Inc.	Evanston				21
22			Alden - Alma Nelson Manor, Inc.	Rockford				22
23			Alden - Park Strathmoor, Inc.	Rockford				23
24			Alden - Meadow Park Health Care Center, Inc.	Clinton, WI				24
25			Alden Estates of Barrington, Inc.	Barrington				25
26			Alden of Waterford, LLC	Aurora				26
27			Alden Springs, Inc.	Bloomingtondale				27
28			Alden Village North, Inc.	Chicago				28
29			Alden Estates of Skokie, Inc.	Skokie				29
30			Alden Estates of Countryside, Inc.	Jefferson, WI				30

Facility Name & ID Number Alden Trails, Inc. # 42051 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	184,204	0.172	0.00	Salary	\$ 796	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	68,345	0.172	0.00	Salary	295	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	39,350	0.172	0.00	Salary	170	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	\$ 1,261		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

Ending: 2/31/2011

(773-724-6622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	Utilities	Patient Days	1,315,389	34	\$ 78,619	\$ 5,662	\$ 338	1
2	24	Trav & Seminar	Patient Days	1,315,389	34	89,570	5,662	386	2
3	25	Other Admin Travel	Patient Days	1,315,389	34	456,762	5,662	1,966	3
4	26	Insurance	Patient Days	1,315,389	34	4,082	5,662	18	4
5	20	Dues & Subscriptions	Patient Days	1,315,389	34	56,361	5,662	243	5
6	30	Depreciation	No of Providers/usage	34	34	291,758	1	8,187	6
7	33	Real Estate Tax	Patient Days/ysage	1,315,389	34	156,401	5,662	607	7
8	35	Rent-Equip & Vehicle	Patient Days	1,315,389	34	1,052,493	5,662	4,530	8
9	32	Interest	Patient Days/usage	1,315,389	34	1,368,621	5,662	6,971	9
10	1	Dietary Salary	Patient Days	1,315,389	34	145,718	145,718	627	10
11	3	Housekeeping Salary	Patient Days	1,315,389	34	217,102	217,102	935	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,315,389	34	207,899	5,662	895	12
13	10	Nurs & Med Records Salary	Patient Days/usage	1,315,389	34	1,184,449	1,184,449	4,856	13
14	15	Employee Benefits -Health Care	Patient Days	1,315,389	34	170,963	5,662	736	14
15	17	Administrative Salary	Patient Days/usage	1,315,389	34	2,886,253	2,886,253	11,349	15
16	27	Employee Benefits - Admin	Patient Days	1,315,389	34	1,372,783	5,662	5,909	16
17	19	Professional fees	Patient Days	1,315,389	34	1,146,467	654,108	4,935	17
18	21	Gen'I & Admin	Patient Days	1,315,389	34	7,066,809	5,970,419	30,419	18
19	6	Repair & Maint.	Patient Days	1,315,389	34	1,343,350	1,077,524	5,782	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 19,296,460	\$ 12,135,573	\$ 89,689	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	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		x	Operating Loss Loan	\$2,122.29	6/02	\$ 339,267	\$ 308,322	9/37	6.8300	\$ 21,193	1	
2	Cambridge		x	Mortgage	\$4,506.29	9/03	873,700	810,220	8/43	5.5000	44,797	2	
3												3	
4	Amortization-Fin/Refin Fee		x	Financing							818	4	
5	Insurance Interest		x	Medical Malpractice							222	5	
	Working Capital												
6	Related party-AMS		x	Working Capital							6,971	6	
7	Related party-FECH		x	Working Capital							16	7	
8												8	
9	TOTAL Facility Related				\$6,628.58		\$ 1,212,967	\$ 1,118,542			\$ 74,017	9	
	B. Non-Facility Related*												
10	Interest Income		x	Replacement Reserve							(11)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (11)	14	
15	TOTALS (line 9+line14)						\$ 1,212,967	\$ 1,118,542			\$ 74,006	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,558 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	13,233	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.)			\$	16,663	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3,430	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	17,149	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.			\$	20,578	7
		Plus: Related Party Taxes (2) - See Pg RE_Tax		614	
Real Estate Tax History:			\$	21,192	
Real Estate Tax Bill for Calendar Year:		2006	15,471	8	
		2007	15,016	9	
		2008	15,707	10	
		2009	16,202	11	
		2010	16,663	12	
The current year accrual is based on an estimated 3% increase of the prior year tax.					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEAlden Trails, Inc.

COUNTYDuPage

FACILITY IDPH LICENSE NUMBER42051

CONTACT PERSON REGARDING THIS REPORTSteven 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>607.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	\$ <u>42,023.00</u>	\$ <u>7.00</u>
3. <u>02-23-301-016</u>	<u>Nursing Home Facility</u>	\$ <u>16,662.68</u>	\$ <u>16,662.68</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></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>359,062.68</u>	\$ <u>17,276.68</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:

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).

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	Building	38,474	1995	\$ 147,679	1
2					2
3	TOTALS	38,474		\$ 147,679	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	16		1997	1997	934,861	23,372	40	23,372		316,139
5										
6										
7										
8										
	Improvement Type**									
9	2 TV Modules		1999		1,775		5			1,775
10	Sprinkler System		1999		1,690	113	15	113		1,447
11	Replace heads-Irrigation system		1998		1,653	110	15	110		1,496
12	Carpentry, Ceramic,Quarry, Corain tops		2003		14,274	714	20	714		6,426
13	Panels		2003		5,175		5			5,175
14	Replaced Floor Tile		2006		2,730	273	10	273		1,592
15	New Sidewalk Ramp Railing-ABC		2008		3,722	248	15	248		1,085
16	Install Automatic Doors-ABC		2008		5,909	591	10	591		1,970
17	Sealcoat Parking Lot - ABC		2009		4,981	623	8	623		1,557
18										
19	Remodel kitchen due to extreme wear - ABC		2011		11,117	417	20	417		417
20	Asphalt removal & replacement sealcoating marking restripe-ROSPAV		2011		6,637	207	8	207		207
21	Valve maintenance/install stocked spare head cabinet - USFIRE		2011		2,500		5			
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 Trails, Inc.

42051

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 997,024	\$ 26,668		\$ 26,668	\$ 0	\$ 339,286	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	Adj for ABC related party profit	2008	(55)	(6)		(6)		(18)	27
28	Adj for ABC related party profit	2009	(66)	(8)		(8)		(20)	28
29	Adj for ABC related party profit	2011	86	3		3		3	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,075,452	\$ 27,615		\$ 27,615	\$ 0	\$ 409,895	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	\$156,103	\$15,246	\$15,246	\$		\$106,521	71
72	Current Year Purchases	19,037	3,031	3,031			2,659	72
73	Fully Depreciated Assets	77,873					77,873	73
74								74
75	TOTALS	\$253,013	\$18,277	\$18,277	\$		\$187,053	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	Bus	2001 - Bus Midwest Transit	2001	\$16,646	\$	\$	\$	5	\$16,646	76
77	Auto-maj repair-patient									77
78	transport	Bus	2000 & 2003	6,558				3	6,558	78
79	Related Party-AMS	Various	98-'02	4,026				3	4,026	79
80	TOTALS			\$27,230	\$	\$	\$		\$27,230	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)	\$1,503,374	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$45,892	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$45,892	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)	\$624,178	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: \$7,158Description: 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	\$256.42	\$3,077	17
18					18
19	Auto lease GL 6890	various	0.00		19
20					20
21	TOTAL		\$256.42	\$3,077	21

10. Effective dates of current rental agreement:

Beginning12/02/1996

Ending11/30/2036

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)	\$					

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	\$		\$	\$		\$	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				4,367		4,367	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-1,39-3, if any								12
13	Other (specify):	See Pg 16A					4,565		4,565	13
14	TOTAL			\$		\$	\$ 8,931		\$ 8,931	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	\$2,399.41
2.	ST	39-3	To Col 5	1,670.27
3.				
4.	PT	39-3	To Col 5	3,180.15
5.				
6.				
7.				
8.	Less PT, OT, & ST costs reclassified to Line 10A for "DD type facilities			(7,250.00)
	Pharmacy Supplies per GL			3,150.72
	Manual Input from Related Party- Forum Drugs			1,216.00
9.	Total to line 9 Pharmacy	See Pg 16A	To Col 6	4,366.72
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	
	Other			12,452.06
	Manual Input: Related Party - Prism			(7,686.00)
	Manual Input: Related Party FECII - I.V.			-
	Manual Input: Related Party FECII - Wound Care			(201.00)
	Radiology(X-Rays) Therapy			
	Oxygen, from reclass worksheet (Pg 4A)			
	Rounding			(0.31)
13.	Col 6: Supplies Total		To Col 6	4,564.75
13.	Total Line 13, Column 8			4,564.75
14.	Total			8,931.30

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100)	702,228	702,228	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		5,702	6
7	Other Prepaid Expenses	1,121	1,121	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 703,349	\$ 709,051	10
	B. Long-Term Assets			
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	34,712	51,827	15
16	Equipment, at Historical Cost	78,634	217,875	16
17	Accumulated Depreciation (book methods)	(83,970)	(486,001)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		8,782	21
22	Other Long-Term Assets (spe Refinancing Fees		14,658	22
23	Other(specify): Due from affiliates	559,771	775,786	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 589,147	\$ 1,661,276	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,292,496	\$ 2,370,327	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 256,259	\$ 256,270	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	867	867	28
29	Short-Term Notes Payable	3,008	17,315	29
30	Accrued Salaries Payable	52,495	52,495	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,013	8,013	31
32	Accrued Real Estate Taxes(Sch.IX-B)		15,400	32
33	Accrued Interest Payable	1,160	5,468	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp,Due HFS,SalesTax,Etc.	2,174	2,174	36
37	Due to affiliates	49,763	49,763	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 373,739	\$ 407,765	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		303,772	39
40	Mortgage Payable		800,463	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliates			43
44	S/holder loans, others			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,104,235	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 373,739	\$ 1,512,000	46
47	TOTAL EQUITY(page 18, line 24)	\$ 918,757	\$ 858,327	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,292,496	\$ 2,370,327	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 916,080	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 916,080	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,677	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)	\$ 2,677	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)	\$ 918,757	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,196,454	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,196,454	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See pg 19A	259,088	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 259,088	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,455,542	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	219,597	31
32	Health Care	443,827	32
33	General Administration	303,782	33
	B. Capital Expense		
34	Ownership	130,050	34
	C. Ancillary Expense		
35	Special Cost Centers	288,514	35
36	Provider Participation Fee	67,095	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,452,865	40
41	Income before Income Taxes (line 30 minus line 40)**	2,677	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,677	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 Trails, 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 payroll wage service fees	\$ 44
Day Training Income	258,566
Gain on Sale of Assets	479
Line 28 Total:	<u>259,088</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
2	Assistant Director of Nursing					2
3	Registered Nurses	1,213	1,247	35,583	28.53	3
4	Licensed Practical Nurses	2,397	2,505	61,107	24.39	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	73	73	1,532	20.99	13
14	Head Cook	4,405	4,405	55,194	12.53	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	520	520	7,655	14.72	17
18	Housekeepers	914	1,054	12,466	11.83	18
19	Laundry					19
20	Administrator	520	520	15,605	30.01	20
21	Assistant Administrator					21
22	Other Administrative					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)	520	520	9,942	19.12	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	23,994	25,444	291,440	11.45	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Fac Mgr, Tran Sp</u>	2,583	2,621	46,453	17.72	33
34	TOTAL (lines 1 - 33)	37,139	38,909	\$ 536,977 *	\$ 13.80	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	100/month	\$ 1,200	1-3	35
36	Medical Director	250/month	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	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	414	22,214	11-3	44
45	Social Service Consultant	6	280	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	420	\$ 27,078		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Johnson, Anna	Administrator	0	\$ 15,605	Workers' Compensation Insurance		\$ 13,692	IDPH License Fee	\$	
		0		Unemployment Compensation Insurance		6,866	Advertising: Employee Recruitment		
		0		FICA Taxes		42,088	Health Care Worker Background Check		
		0		Employee Health Insurance		15,779	(Indicate # of checks performed 13)	130	
		0		Employee Meals		7,083	Patient Background Checks	0	
		0		Illinois Municipal Retirement Fund (IMRF)*			Surety Bond Fees	125	
		0		Dental Insurance		44	IHCA dues less PAC fees	618	
				Life Insurance		422	Allscripts	205	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Relations & Misc. Payroll Costs		306	Related Party - Bloomingdale	135	
(List each licensed administrator separately.)			\$ 15,605	Employee Drug Tests		208	Related Party - AMS	243	
B. Administrative - Other									
Description			Amount	401K Match		136	Less: Public Relations Expense	()	
			\$	Employee Vaccinations		283	Non-allowable advertising	()	
				Offset Miscellaneous Income		(44)	Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)			\$ 86,863	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,456
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services									
Vendor/Payee	Type		Amount				Out-of-State Travel	\$	
Alden Management Services, Inc.	Consulting		\$ 83,752						
AMS (Eliminated)	Allocated Legal Fees		18,000						
MidCap (Eliminated)	Allocated Legal Fees		415						
Medifax/EDI	Billing Service		37				In-State Travel		
MidCap (Eliminated)	Allocated Accounting Fees		208						
BDO Seidman	Accounting Fees		1,955						
Baker Tilly/Virchow Krause	Audit Fees		1,779				Related Party - AMS	386	
							Seminar Expense		
							IHCA	15	
							Safety/Sanitation Seminar	354	
							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.)			\$ 106,146				TOTAL	\$ 755	

*** 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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting	12/08	\$ 3,848	3	\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,848		\$	\$ 107	\$ 1,283	\$ 1,283	\$ 1,175	\$	\$	\$	\$

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. \$ 7,548 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 No 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. \$ 67,095
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. \$ 7,083 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.