

		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: 004-9122

Facility Name: Alden Village North, Inc.

Address: 7464 N. Sheridan Rd. Chicago 60626
Number City Zip Code

County: Cook

Telephone Number: 773-338-0200 Fax # 773-338-5122

HFS ID Number:

Date of Initial License for Current Owners: 1/3/08

Type of Ownership:

☐	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		

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 Village North, Inc.

004-9122 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	150	Skilled Pediatric (SNF/PED)	150	54,750	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	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	27,021	165	22	27,208	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,021	165	22	27,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.69%

D. How many bed-hold days during this year were paid by the Department? 994 (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 1/3/08

J. Was the facility purchased or leased after January 1, 1978? YES x Date 1/3/08 NO

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 Not Applicable

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 Village North, Inc. # 004-9122 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	261,925	28,978	14,800	305,703	11,072	316,775	(3,973)	312,802			1
2	Food Purchase		429,035		429,035	(30,431)	398,604	(176,902)	221,702			2
3	Housekeeping	153,397	46,320		199,717	9,844	209,561	4,491	214,052			3
4	Laundry	146,391	25,257	5,725	177,373		177,373		177,373			4
5	Heat and Other Utilities			184,706	184,706		184,706	1,304	186,010			5
6	Maintenance	43,333		234,429	277,762		277,762	(12,544)	265,218			6
7	Other (specify):* Security / Related Party			284	284		284	7,145	7,429			7
8	TOTAL General Services	605,046	529,590	439,944	1,574,580	(9,515)	1,565,065	(180,479)	1,384,586			8
	B. Health Care and Programs											
9	Medical Director			38,833	38,833		38,833		38,833			9
10	Nursing and Medical Records	3,228,839	153,275	10,027	3,392,141	106,272	3,498,413	24,588	3,523,001			10
10a	Therapy		408		408	638,059	638,467	23,862	662,329			10a
11	Activities	25,776	7,153	148,114	181,043		181,043		181,043			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related party							3,536	3,536			15
16	TOTAL Health Care and Programs	3,254,615	160,836	196,974	3,612,425	744,331	4,356,756	51,986	4,408,742			16
	C. General Administration											
17	Administrative	86,781			86,781		86,781	159,728	246,509			17
18	Directors Fees											18
19	Professional Services			798,529	798,529	(135,370)	663,159	(280,271)	382,888			19
20	Dues, Fees, Subscriptions & Promotions			210,258	210,258		210,258	(195,845)	14,413			20
21	Clerical & General Office Expenses	170,130	18,882	58,465	247,477	1,837	249,314	213,568	462,882			21
22	Employee Benefits & Payroll Taxes			814,396	814,396	1,918	816,314	(1,387)	814,927			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,982	4,982		4,982	1,753	6,735			24
25	Other Admin. Staff Transportation			5,109	5,109		5,109	9,448	14,557			25
26	Insurance-Prop.Liab.Malpractice			159,428	159,428		159,428	84	159,512			26
27	Other (specify):* Related party			50,011	50,011		50,011	(14,688)	35,323			27
28	TOTAL General Administration	256,911	18,882	2,101,178	2,376,971	(131,615)	2,245,356	(107,610)	2,137,746			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,116,572	709,308	2,738,096	7,563,976	603,201	8,167,177	(236,103)	7,931,074			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			50,752	50,752		50,752	397,414	448,166			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,874	40,874		40,874	586,076	626,950			32
33	Real Estate Taxes			113,093	113,093	(113,093)		116,044	116,044			33
34	Rent-Facility & Grounds			620,420	620,420	113,093	733,513	(733,513)				34
35	Rent-Equipment & Vehicles			14,734	14,734		14,734	21,770	36,504			35
36	Other (specify):*							6,039	6,039			36
37	TOTAL Ownership			839,873	839,873		839,873	393,830	1,233,703			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,935	581,772	765,707	(603,201)	162,506	(19,234)	143,272			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			381,781	381,781		381,781		381,781			42
43	Other (specify):* DD Day Training			540,963	540,963		540,963		540,963			43
44	TOTAL Special Cost Centers		183,935	1,504,516	1,688,451	(603,201)	1,085,250	(19,234)	1,066,016			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,116,572	893,243	5,082,485	10,092,300		10,092,300	138,493	10,230,793			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	22	(30,431) 30,431	Employee Meals Employee Meals
22	1	(28,513) 11,072	Uniforms Uniforms
	3	9,844	Uniforms
	4	-	Uniforms
	6	-	Uniforms
	10	5,760	Uniforms
	11	-	Uniforms
	21	1,837	Uniforms
10	39	(34,858) 34,858	Oxygen - to appropriate cost center Oxygen - to appropriate cost center
33	34	(113,093) 113,093	Rent - Real Estate Tax on associated landowner (Pg 6) Rent - Real Estate Tax on associated landowner (Pg 6)
19	33	none none	Reclass from Professional Fees to Real Estate tax Reclass from Professional Fees to Real Estate tax
21		none none	Vendor Settlements Vendor Settlements (may effect more than one line)
39	10a	(581,772) 581,772	PT, OT, ST, & RT Therapy Costs PT, OT, ST, & RT Therapy Costs
39	10a	(56,287) 56,287	Vent Supplies (related to RT) Vent Supplies (related to RT)
Others, if any:			
19	10	(135,370) 135,370	Clinical Coordinators (Pathway Billing) Clinical Coordinators (Pathway Billing)
19	21	none none	MediFax/MedCom 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	(2,330)	2		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	(8,718)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	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	(2,420)	21		17
18	Fines and Penalties	(38,373)	32		18
19	Entertainment	(5,480)	20		19
20	Contributions	(15,578)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,107)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,011)	27		24
25	Fund Raising, Advertising and Promotional	(127,417)	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)	\$ (258,443)		\$	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)	418,956	Various	34
35	Other- Attach Schedule	(22,020)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 396,936		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 138,493		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

Report Period Beginning:

Ending:

ID#

004-9122

1/1/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (3,403)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(9,476)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	1,896	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	18,488	6	4
5				5
6	Elim ABC Deprec Exp from Pg 12 series -	(56)	30	6
7				7
8	Utility Late Fees	(322)	5	8
9	Other Nursing Income (Flu shots)	(140)	21	9
10	Misc Income-Garnishment Processing	(84)	22	10
11	Misc Income-Record Copies	(353)	21	11
12	Marketing Manager	(6,657)	21	12
13	Marketing Manager Benefits	(1,303)	22	13
14	Back out PAC fees - IHCA at 30%	(207)	20	14
15	Deming Training Adjustment	(100)	24	15
16	Eliminate Chamber of Commerce contribution	(237)	20	16
17	Adj Real Estate Tax variance	(15)	33	17
18	Eliminate Marketing Translation Service(from Prof Fees)	(497)	19	18
19	Deduct Legal Accrual for Dec 2011-no invoice	(20,000)	19	19
20	Add 2011 legal invoice not booked in 2011	446	19	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	(22,020)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Village North, Inc. # 004-9122 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	3,014	(6,987)	0	0	0	0	0	0	0	(3,973)	1
2	Food Purchase	(2,339)	0	0	(174,563)	0	0	0	0	0	0	0	(176,902)	2
3	Housekeeping	0	0	4,491	0	0	0	0	0	0	0	0	4,491	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(322)	0	1,626	0	0	0	0	0	0	0	0	1,304	5
6	Maintenance	20,384	0	(33,221)	0	0	0	293	0	0	0	0	(12,544)	6
7	Other (specify):*	0	0	4,300	2,845	0	0	0	0	0	0	0	7,145	7
8	TOTAL General Services	17,723	0	(19,790)	(178,705)	0	0	293	0	0	0	0	(180,479)	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	23,337	34	1,217	0	0	0	0	0	0	24,588	10
10a	Therapy	0	0	0	0	0	23,862	0	0	0	0	0	23,862	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	3,536	0	0	0	0	0	0	0	0	3,536	15
16	TOTAL Health Care and Programs	0	0	26,873	34	1,217	23,862	0	0	0	0	0	51,986	16
	C. General Administration													
17	Administrative	0	2	159,726	0	0	0	0	0	0	0	0	159,728	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(28,158)	0	(252,113)	0	0	0	0	0	0	0	0	(280,271)	19
20	Fees, Subscriptions & Promotions	(148,919)	250	(47,176)	0	0	0	0	0	0	0	0	(195,845)	20
21	Clerical & General Office Expenses	(9,570)	6,909	146,173	66,696	3,360	0	0	0	0	0	0	213,568	21
22	Employee Benefits & Payroll Taxes	(1,387)	0	0	0	0	0	0	0	0	0	0	(1,387)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(100)	0	1,853	0	0	0	0	0	0	0	0	1,753	24
25	Other Admin. Staff Transportation	0	0	9,448	0	0	0	0	0	0	0	0	9,448	25
26	Insurance-Prop.Liab.Malpractice	0	0	84	0	0	0	0	0	0	0	0	84	26
27	Other (specify):*	(50,011)	0	28,395	7,117	(189)	0	0	0	0	0	0	(14,688)	27
28	TOTAL General Administration	(238,145)	7,161	46,390	73,813	3,171	0	0	0	0	0	0	(107,610)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(220,422)	7,161	53,473	(104,858)	4,388	23,862	293	0	0	0	0	(236,103)	29

Summary B

12/31/2011

	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	(12,935)	402,161	8,188	0	0	0	0	0	0	0	0	397,414	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47,091)	629,164	3,893	0	110	0	0	0	0	0	0	586,076	32
33	Real Estate Taxes	(15)	113,093	2,918	0	48	0	0	0	0	0	0	116,044	33
34	Rent-Facility & Grounds	0	(733,513)	0	0	0	0	0	0	0	0	0	(733,513)	34
35	Rent-Equipment & Vehicles	0	0	21,770	0	0	0	0	0	0	0	0	21,770	35
36	Other (specify):*	0	6,039	0	0	0	0	0	0	0	0	0	6,039	36
37	TOTAL Ownership	(60,041)	416,944	36,769	0	158	0	0	0	0	0	0	393,830	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	(26,661)	7,427	0	0	0	0	0	0	(19,234)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(26,661)	7,427	0	0	0	0	0	0	(19,234)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(280,463)	424,105	90,242	(131,519)	11,973	23,862	293	0	0	0	0	138,493	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		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 733,513	Alden Village North II, LLC	0.00%	\$	\$ (733,513)	1
2	V	32	Interest Income - Repl Reserve	6	Alden Village North II, LLC			(6)	2
3	V	17	Administrative		Alden Village North II, LLC		2	2	3
4	V	19	Professional Fees		Alden Village North II, LLC				4
5	V	33	Real Estate Tax		Alden Village North II, LLC		113,093	113,093	5
6	V	20	Dues & Subscriptions		Alden Village North II, LLC		250	250	6
7	V	32	Fines & Penalties		Alden Village North II, LLC				7
8	V	21	General Insurance		Alden Village North II, LLC		6,909	6,909	8
9	V	36	Mortgage Insurance Premium		Alden Village North II, LLC		6,039	6,039	9
10	V	32	Mortgage Interest		Alden Village North II, LLC		622,249	622,249	10
11	V	30	Depreciation		Alden Village North II, LLC		402,161	402,161	11
12	V	32	Amortization		Alden Village North II, LLC		6,921	6,921	12
13	V	21	Bank Fees		Alden Village North II, LLC				13
14	Total			\$ 733,519			\$ 1,157,624	\$ * 424,105	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%	\$ 1,626	\$ 1,626	15
16	V	24	Trav & Seminar		Alden Management Services, Inc.		1,853	1,853	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		9,448	9,448	17
18	V	26	Insurance		Alden Management Services, Inc.		84	84	18
19	V	20	Dues & Subscriptions		Alden Management Services, Inc.		1,166	1,166	19
20	V	30	Depreciation		Alden Management Services, Inc.		8,188	8,188	20
21	V	32	Amortization		Alden Management Services, Inc.				21
22	V	33	Real Estate Tax		Alden Management Services, Inc.		2,918	2,918	22
23	V	35	Rent -Equip & Vehicles		Alden Management Services, Inc.		21,770	21,770	23
24	V	32	Interest		Alden Management Services, Inc.		3,893	3,893	24
25	V	1	Dietary		Alden Management Services, Inc.		3,014	3,014	25
26	V	3	Housekeeping		Alden Management Services, Inc.		4,491	4,491	26
27	V	7	Employee Benefits -Gen'L Servs		Alden Management Services, Inc.		4,300	4,300	27
28	V	10	Nurs & Med Records Salary		Alden Management Services, Inc.		23,337	23,337	28
29	V	15	Employee Benefits -Health Care		Alden Management Services, Inc.		3,536	3,536	29
30	V	17	Administrative Salary		Alden Management Services, Inc.		159,726	159,726	30
31	V	27	Employee Benefits - Admin		Alden Management Services, Inc.		28,395	28,395	31
32	V	19	Professional Fees		Alden Management Services, Inc.		23,714	23,714	32
33	V	21	Gen'I & Admin		Alden Management Services, Inc.		146,173	146,173	33
34	V	6	Repair & Maint.		Alden Management Services, Inc.		27,786	27,786	34
35	V	19	Consulting & Legal	275,827	Alden Management Services, Inc.			(275,827)	35
36	V	6	Maintenance Allocation Charges	61,007	Alden Management Services, Inc.			(61,007)	36
37	V	20	Marketing Mgmt Fees	48,342	Alden Management Services, Inc.			(48,342)	37
38	V								38
39	Total			\$ 385,176			\$ 475,418	\$ * 90,242	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	Diet. Consultant	\$ 14,800	Prism Health Care Services, Inc.	0.00%	\$ 246	\$ (14,554)	15
16	V	1	Dietarty Salary		Prism Health Care Services, Inc.		7,567	7,567	16
17	V	2	Tube Feeding	248,996	Prism Health Care Services, Inc.		74,433	(174,563)	17
18	V	10	Equip. Rental	6,660	Prism Health Care Services, Inc.		6,694	34	18
19	V	39	Ancillary Supplies	99,948	Prism Health Care Services, Inc.		45,533	(54,415)	19
20	V	39	Vent Rental		Prism Health Care Services, Inc.		27,754	27,754	20
21	V	21	Gen'L & Admin Salary		Prism Health Care Services, Inc.		42,661	42,661	21
22	V	27	Employee Benefits		Prism Health Care Services, Inc.		7,117	7,117	22
23	V	7	Employee Benefits		Prism Health Care Services, Inc.		2,845	2,845	23
24	V	21	Gen'l & Admin		Prism Health Care Services, Inc.		24,035	24,035	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			\$ 370,404			\$ 238,885	\$ * (131,519)	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	\$ 22,217	Forum Extended Care Services II, Inc.	0.00%	\$ 30,789	\$ 8,572	15
16	V	39	IV		Forum Extended Care Services II, Inc.				16
17	V	39	Wound Care	5,482	Forum Extended Care Services II, Inc.		4,337	(1,145)	17
18	V	10	House Stock	9,580	Forum Extended Care Services II, Inc.		8,864	(716)	18
19	V	10	Pharmacy Consultant	2,580	Forum Extended Care Services II, Inc.		4,513	1,933	19
20	V	27	Employee Vaccin.	2,160	Forum Extended Care Services II, Inc.		1,708	(452)	20
21	V	27	Employee Benefits: G&A		Forum Extended Care Services II, Inc.		263	263	21
22	V	21	Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		2,117	2,117	22
23	V	21	Gen'l & Admin		Forum Extended Care Services II, Inc.		1,243	1,243	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		110	110	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		48	48	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			\$ 42,019			\$ 53,992	\$ * 11,973	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	Ancillary	\$ 178,145	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 202,007	\$ 23,862	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			\$ 178,145			\$ 202,007	\$ * 23,862	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 and Maintenance	\$ 37,662	Alden Bennett Construction Company, Inc.	0.00%	\$ 37,955	\$ 293	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			\$ 37,662			\$ 37,955	\$ * 293	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								28
29			Alden Estates of Skokie, Inc.	Skokie				29
30			Alden Estates of Countryside, Inc.	Jefferson, WI				30

Facility Name & ID Number Alden Village North, Inc. # 004-9122 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	181,173	0.83	2.07	Salary	\$ 3,827	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	67,220	0.83	2.07	Salary	1,420	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,703	0.83	2.07	Salary	817	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	\$ 6,064		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	\$ 27,208	\$ 1,626	1
2	24	Trav & Seminar	Patient Days	1,315,389	34	89,570	27,208	1,853	2
3	25	Other Admin Travel	Patient Days	1,315,389	34	456,762	27,208	9,448	3
4	26	Insurance	Patient Days	1,315,389	34	4,082	27,208	84	4
5	20	Dues & Subscriptions	Patient Days	1,315,389	34	56,361	27,208	1,166	5
6	30	Depreciation	No of Providers/Usage	34	34	291,758	1	8,188	6
7	33	Real Estate Tax	Patient Days/Usage	1,315,389	34	156,401	27,208	2,918	7
8	35	Rent-Equip & Vehicle	Patient Days	1,315,389	34	1,052,493	27,208	21,770	8
9	32	Interest	Patient Days/Usage	1,315,389	34	1,368,621	27,208	3,893	9
10	1	Dietary	Patient Days	1,315,389	34	145,718	145,718	3,014	10
11	3	Housekeeping	Patient Days	1,315,389	34	217,102	217,102	4,491	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,315,389	34	207,899	27,208	4,300	12
13	10	Nurs & Med Records Salary	Patient Days/Usage	1,315,389	34	1,184,499	1,184,449	23,337	13
14	15	Employee Benefits -Health Care	Patient Days	1,315,389	34	170,963	27,208	3,536	14
15	17	Administrative Salary	Patient Days/Usage	1,315,389	34	2,886,253	2,886,253	57,331	15
16	27	Employee Benefits - Admin	Patient Days	1,315,389	34	1,372,783	27,208	28,395	16
17	19	Professional fees	Patient Days	1,315,389	34	1,146,467	654,108	23,714	17
18	21	Gen'I & Admin	Patient Days	1,315,389	34	7,066,809	5,970,419	146,173	18
19	6	Repair & Maint.	Patient Days	1,315,389	34	1,343,350	1,077,524	27,786	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 19,296,510	\$ 12,135,573	\$ 373,023	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 Realty Capital, Ltd.		x	Mortgage	\$70,406.00	12/1/09	\$ 12,960,000	\$ 12,926,238	7/1/2051	5.9000	\$ 622,249	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Related party-AMS		x	Working Capital							3,893	6	
7	Related party-FECH		x	Working Capital							110	7	
8	Related party-AMS		x	Malpractice Insurance Financing							2,501	8	
9	TOTAL Facility Related				\$70,406.00		\$ 12,960,000	\$ 12,926,238			\$ 628,753	9	
	B. Non-Facility Related*												
10	Interest Income on Repl Reserve										(6)	10	
11	Utility Deposit Interest Income										(13)	11	
12	Int Income - IL Medicaid										(8,705)	12	
13	Amort of Fin Fees										6,921	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,803)	14	
15	TOTALS (line 9+line14)						\$ 12,960,000	\$ 12,926,238			\$ 626,950	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,039 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.			\$	107,100	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.)			\$	108,478	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,378	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	111,700	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.			\$	113,078	7
		Plus: Related Party Taxes (2) - See Pg RE_Tax		2,966	
Real Estate Tax History:			\$	116,044	
Real Estate Tax Bill for Calendar Year:		2006			8
		2007	101,192		9
		2008	102,208		10
		2009	103,953		11
		2010	108,478		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 Village North, Inc.COUNTYCook

FACILITY IDPH LICENSE NUMBER004-9122

CONTACT PERSON REGARDING THIS REPORTSteven M. Kroll

TELEPHONE(773) 724-6622FAX #:(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>2,918.00</u>
2. <u>See attached supplement</u>	<u>Related Party-Forum Extended Care</u>	\$ <u>48,923.00</u>	\$ <u>48.00</u>
3. <u>11-29-307-019-0000</u>	<u>7404 N. Sheridan Rd-Nursing Facility</u>	\$ <u>24,847.16</u>	\$ <u>24,847.16</u>
4. <u>11-29-307-020-0000</u>	<u>7404 N. Sheridan Rd-Nursing Facility</u>	\$ <u>23,970.87</u>	\$ <u>23,970.87</u>
5. <u>11-29-307-022-0000</u>	<u>7404 N. Sheridan Rd-Nursing Facility</u>	\$ <u>59,660.12</u>	\$ <u>59,660.12</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>457,778.15</u>	\$ <u>111,444.15</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:

51,814

B. General Construction Type:

Exterior

Load Bearing CMU, Br

Frame

Steel Stud

Number of Stories

3+Basement

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing facility	33,315	2008	\$ 358,296	1
2					2
3	TOTALS	33,315		\$ 358,296	3

Facility Name & ID Number Alden Village North, Inc.

004-9122

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		2008	1968	\$ 2,984,341	\$ 76,522	39	\$ 76,522	\$	\$ 306,088	4
5	Construction	Project HUD 2009-2011		2011	6,830,905	131,364	39	131,364		131,364	5
6											6
7											7
8	Related Party-Forum			1978	13,669		25			14,056	8
	Improvement Type**										
9	ABC-Doors		2008		5,996	600	10	600		2,349	9
10	ABC-Doors		2008		3,091	309	10	309		1,185	10
11	A&B Cable-Cable lines		2008		4,230	423	10	423		1,622	11
12	ABC-Remodel - plumbing		2008		4,635	927	5	927		3,322	12
13	ABC-Door entry system		2008		2,850	285	10	285		950	13
14	ABC-Hvac- major repair to system		2008		4,583	917	5	917		3,667	14
15	Capps-Drains - major repairs		2008		3,875	775	5	775		2,971	15
16	Renovate-gen'l labor AMS		2008		10,664	2,133	5	2,133		7,821	16
17	Renovate-gen'l labor AMS		2008		11,352	2,270	5	2,270		8,135	17
18	Capps-Repipe shower lines		2008		4,585	917	5	917		3,057	18
19	ABCPlumbing - major repair		2008		4,885	977	5	977		3,012	19
20	Wire building for cable		2009		6,518	652	10	652		1,901	20
21	Wire building for cable		2009		6,240	624	10	624		1,820	21
22	Wire building for cable		2009		2,800	280	10	280		723	22
23	ABCPlumbing - major repair		2009		17,539	877	20	877		2,558	23
24	ABC-Replace elevator shaft		2009		9,794	490	20	490		1,388	24
25	ABC-Replace elevator shaft		2009		39,178	1,959	20	1,959		5,550	25
26	Central States-Replace sprinkler alarm panel		2009		2,650	530	5	530		1,546	26
27	Patten-Major generator repair		2009		2,992	598	5	598		1,745	27
28	Patten-Major generator repair		2009		10,604	2,121	5	2,121		5,656	28
29	Fire sprinkler repair & corrections Focus Fire		2010		2,672	534	5	534		623	29
30	ABC-Carpet, Kitchen Equip, Fire Alarms		2011		19,006	739	15	739		739	30
31	ABC-Plumbing,Elevator Equip, Drywall		2011		22,489	625	15	625		625	31
32	ABC-Electrical,Paving,Millwork,Countertops		2011		19,567	435	15	435		435	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Village North, Inc.

004-9122

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		\$ 10,051,710	\$ 228,882		\$ 228,882	\$	\$ 514,908	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		7			6,295	22
23									23
24									24
25	Adj for ABC Related Party Profit	2008	(173)	(32)		(32)		(112)	25
26	Adj for ABC Related Party Profit	2009	(878)	(38)		(38)		(114)	26
27	Adj for ABC Related Party Profit-None	2010							27
28	Adj for ABC Related Party Profit	2011	475	14		14		14	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,129,597	\$ 229,784		\$ 229,784	\$	\$ 585,340	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	\$510,989	\$93,514	\$93,514	\$	Various	\$347,189	71
72	Current Year Purchases	832,273	124,868	124,868		Various	124,868	72
73	Fully Depreciated Assets	58,066				Various	58,066	73
74								74
75	TOTALS	\$1,401,328	\$218,382	\$218,382	\$		\$530,123	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party-AMS	Various	98-02	\$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 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,893,247	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$448,166	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$448,166	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)	\$1,119,489	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 Eliminated
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☐ YES☒ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy:☐ YES☒ NO
- Terms:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$11,968Description:Copy Machine Lease, Office Equipmenet Lease
(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	\$ #####	\$ 14,787	17
18					18
19	Auto lease GL 6890	various	501.33	6,016	19
20					20
21	TOTAL		\$ #####	\$ 20,803	21

10. Effective dates of current rental agreement:

Beginning1/2/08

Ending1/2/18

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$ 1,147,473
13.	/2013	\$ 1,150,399
14.	/2014	\$ 1,153,401

* 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	\$		\$	\$		\$	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				30,789		30,789	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Except Care Prgrm	39-1,39-3, if any					0			12
13	Other (specify): See Pg 16A						112,483		112,483	13
14	TOTAL			\$		\$	\$ 143,272		\$ 143,272	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)			

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	38,296
2. ST	39-3	To Col 5	51,114
3.			
4. PT	39-3	To Col 5	63,535
5.			
6.			
7.			
8.			
Less: OT, ST, & PT costs - reclassified to 10A for DD facilities			(152,945)
Total Lines 1,2 & 4			0.00
Pharmacy Supplies per GL			22,217
Manual Input from Related Party- Forum Drugs			8,572
9. Total to line 9 Pharmacy	See Pg 16A	To Col 6	30,789
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col. 3	-
12. Exceptional Care-Supplies:	See pg 16A	To Col. 6	56,287
Reclass Vent Supplies to Ln 10A, with other RT costs			(56,287)
Total Exceptional Care (Line 12, Col 8)			(0)
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT	To Col 5		-
Other			534,259
Less: Respiratory Therapy Costs reclassified to line 10A on Pg 4A			(428,827)
Manual Input: Related Party - Prism			(26,661)
Manual Input: Related Party FECII - I.V.			-
Manual Input: Related Party FECII - Wound Care			(1,146)
Oxygen, from Pg 4A reclass worksheet			34,858
13. Col 6: Supplies Total		To Col 6	112,483
13. Total Line 13, Column 8			112,483
14. Total			143,272

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	\$ 2,500	\$ 12,196	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 45,000)	1,996,200	1,996,200	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		8,668	6
7	Other Prepaid Expenses	31,055	109,589	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)	\$ 2,029,755	\$ 2,126,653	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		358,296	13
14	Buildings, at Historical Cost		9,815,246	14
15	Leasehold Improvements, at Historical Cost	283,802	348,398	15
16	Equipment, at Historical Cost	220,594	1,388,688	16
17	Accumulated Depreciation (book methods)	(256,947)	(1,098,673)	17
18	Deferred Charges	94,600	540,748	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		142,144	21
22	Other Long-Term Assets (spe Repl resrv, CIP, S/holders			22
23	Other(specify): Due from affiliates			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 342,049	\$ 11,494,847	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,371,804	\$ 13,621,500	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 924,378	\$ 953,301	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,171	7,171	28
29	Short-Term Notes Payable		84,488	29
30	Accrued Salaries Payable	388,513	388,513	30
31	Accrued Taxes Payable (excluding real estate taxes)	66,157	66,157	31
32	Accrued Real Estate Taxes(Sch.IX-B)		111,700	32
33	Accrued Interest Payable		63,554	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp,Due HFS,SalesTax,Etc.	263,707	273,707	36
37	Due to affiliates	1,392,085	1,432,305	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,042,011	\$ 3,380,896	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		12,841,749	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliates	3,905,539	2,874,851	43
44	S/holder loans, others			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,905,539	\$ 15,716,600	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,947,550	\$ 19,097,496	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,575,746)	\$ (5,475,996)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,371,804	\$ 13,621,500	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,029,228)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,029,228)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,546,518)	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)	\$ (3,546,518)	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)	\$ (4,575,746)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Village North, Inc.

004-9122

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,969,767	1
2	Discounts and Allowances for all Levels	(250)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,969,517	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	47,918	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 47,918	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	(21,861)	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(50)	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	140	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (21,771)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,718	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,718	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Day Training Revenue</u>	540,963	28
28a	<u>Misc Revenue</u>	437	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 541,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,545,782	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,574,580	31
32	Health Care	3,612,425	32
33	General Administration	2,376,971	33
	B. Capital Expense		
34	Ownership	839,873	34
	C. Ancillary Expense		
35	Special Cost Centers	1,306,670	35
36	Provider Participation Fee	381,781	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,092,300	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,546,518)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,546,518)	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 Village North, 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-Garnishment Processing - backed out on 5A	\$ 84
Misc Income-Record Copies - backed out on 5A	353
Day Training Income (not offset, actual costs reported)	540,963
Line 28 Total:	<u>541,400</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	2,040	2,040	\$ 83,598	\$ 40.98	1
2	Assistant Director of Nursing	2,080	2,141	72,441	33.84	2
3	Registered Nurses	22,143	23,170	716,196	30.91	3
4	Licensed Practical Nurses	19,763	20,675	498,070	24.09	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	880	880	18,462	20.98	9
10	Activity Assistants	629	636	7,314	11.50	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,000	2,000	42,000	21.00	13
14	Head Cook	8	8	91	11.38	14
15	Cook Helpers/Assistants	17,338	19,340	219,834	11.37	15
16	Dishwashers					16
17	Maintenance Workers	1,968	1,992	43,333	21.75	17
18	Housekeepers	13,535	14,486	153,397	10.59	18
19	Laundry	14,282	15,080	146,391	9.71	19
20	Administrator					20
21	Assistant Administrator	3,552	3,671	86,781	23.64	21
22	Other Administrative	4,240	4,240	79,145	18.67	22
23	Office Manager	2,072	2,072	44,473	21.46	23
24	Clerical	2,597	2,877	29,697	10.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,816	7,836	124,377	15.87	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	139,958	147,725	1,692,342	11.46	30
31	Medical Records					31
32	Other Health Care Unit Manager	2,182	2,390	41,815	17.50	32
33	Other(specify) Schl Nrse Lias/Res	572	572	16,815	29.40	33
34	TOTAL (lines 1 - 33)	259,655	273,831	\$ 4,116,572 *	\$ 15.03	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	flat monthly fee	\$ 14,800	1-3	35
36	Medical Director	flat monthly fee	38,833	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	flat monthly fee	1,748		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	\$75.98/res semi n	146,047	11-3	44
45	Social Service Consultant	8 hrs	280	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 201,708		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			
Name	Function	%	Amount
GIORDANO, CHRISTIANE	Asst Admin	0	\$ 31,671
WALSKI, KRISTOPHER R	Asst Admin	0	50,461
WINKLER, CAROLINE E	Asst Admin	0	4,649
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			\$ 86,781
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$
(Attach a copy of any management service agreement)			
C. Professional Services			
Vendor/Payee	Type		Amount
Alden Management Services	Consulting Fees	\$	239,827
AMS (Eliminated)	Allocated Legal Fees		36,000
Baker Tilly Virchow Krause, LLP	Accounting Services		7,555
Ken Fisch	Legal Fees		8,107
BDO Seidman	Tax Prep Services		2,481
MedCom/Linda Roberts & Assoc	Billing Consultant/Dietary Cons		492
First Advantage	Tax Services		598
Ungaretti Harris	Legal Fees		343,875
Pacific Interpreters/Dr. Richard Kat	Deposition Translation/Witness		4,878
Johnson & Bell/B&F Consulting/Via	Legal/Clinical Consulting/Mkg]		7,976
Pathway Health Services	Clinical Consultants		135,370
Michigan Peer Review Organization	Quality Control & Review		11,370
TOTAL (agree to Schedule V, line 19, column 3)			
(If total legal fees exceed \$5,000, attach copy of invoices.)		\$	798,529
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	143,060
Unemployment Compensation Insurance			83,980
FICA Taxes			326,206
Employee Health Insurance			45,076
Employee Meals			30,431
Illinois Municipal Retirement Fund (IMRF)*			
Chicago Head Tax			5,076
Union Health & Welfare			127,054
Dental & Life Insurance			371
Pension & 401K Match			46,188
Employee Drug Testing/Vaccinations			4,808
Empl. Relations & Misc Payroll Costs			3,980
Marketing Manager Benefits Eliminated			(1,303)
TOTAL (agree to Schedule V,		\$	814,927
line 22, col.8)			
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
None		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			323
Health Care Worker Background Check			1,560
(Indicate # of checks performed)	156		
Patient Background Checks	46		460
IL Assn of Health Care Facilities			900
Surety Bonds			1,506
IL Health Care Assn less PAC			8,073
Collaborative Healthcare/Chamber of Commr			175
Related party-AMS/Vill North LLC Sec of St			1,416
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V,		\$	14,413
line 20, col. 8)			
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Related parties-AMS			1,853
Seminar Expense			
Deming Leadership Training (Net)			400
Illinois Health Care Assn convention			1,028
Various Seminar / Training Expenses			3,454
Entertainment Expense		(	)
(agree to Sch. V,			
TOTAL line 24, col. 8)		\$	6,735

*** 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	2008	\$ 87,992	3	\$	\$ 17,851	\$ 29,331	\$ 29,331	\$ 11,479	\$	\$	\$	\$
2	Painting	1/09	12,330	3			3,768	4,110	4,110	342			
3	Painting/Tinting	01/11	1,097	5					201	219	219	219	219
4	Painting	12/11	822	3						274	274	274	
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 102,241		\$	\$ 17,851	\$ 33,099	\$ 33,441	\$ 15,790	\$ 835	\$ 493	\$ 493	\$ 219

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

yes (habilitation aides)

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

IHCA=\$8,073

Il. Assoc. of HC=\$900

(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.

\$ 22,138

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.

\$ 381,781

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.

\$ 30,431

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?

Yes

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

\$ 0
- (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 out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

yes

Attach invoices and a summary of services for all architect and appraisal fees.