

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0040709</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Alden Lincoln Rehab & Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>504 West Wellington Avenue</u> <u>Chicago</u> <u>60657</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 281 - 6200</u> Fax # <u>(773) 281 - 5623</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Joan Carl</u></td></tr><tr><td>(Title) <u>Vice-President</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Joan Carl</u>	(Title) <u>Vice-President</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Joan Carl</u>																								
	(Title) <u>Vice-President</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>03/01/95</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>																									
Email Address: _____																									

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center# 0040709 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>96</u>	Skilled (SNF)	<u>96</u>	<u>35,136</u>	1
2		Skilled Pediatric (SNF/PED)		<u>0</u>	2
3		Intermediate (ICF)		<u>0</u>	3
4		Intermediate/DD		<u>0</u>	4
5		Sheltered Care (SC)		<u>0</u>	5
6		ICF/DD 16 or Less		<u>0</u>	6
7	<u>96</u>	TOTALS	<u>96</u>	<u>35,136</u>	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	<u>3,372</u>	<u>901</u>	<u>1,962</u>	<u>6,235</u>	8
9	SNF/PED					9
10	ICF	<u>19,198</u>	<u>1,266</u>	<u>1,848</u>	<u>22,312</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,570</u>	<u>2,167</u>	<u>3,810</u>	<u>28,547</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.25%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 03/01/95NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 33 and days of care provided 1,361Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	213,620	18,440	22,800	254,860	1,376	256,236	(6,600)	249,636		1
2	Food Purchase		249,417		249,417	(30,259)	219,158	(48,207)	170,951		2
3	Housekeeping	111,112	35,035		146,147	434	146,581	3,217	149,798		3
4	Laundry	50,321	9,343		59,664	524	60,188		60,188		4
5	Heat and Other Utilities			106,046	106,046		106,046	745	106,791		5
6	Maintenance	69,218		187,418	256,636	1,080	257,716	(1,806)	255,910		6
7	Other (specify):* related party							4,750	4,750		7
8	TOTAL General Services	444,271	312,235	316,264	1,072,770	(26,845)	1,045,925	(47,901)	998,024		8
	B. Health Care and Programs										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	1,493,819	142,467	11,798	1,648,084	(25,743)	1,622,341	24,477	1,646,818		10
10a	Therapy	53,133	4,222		57,355		57,355		57,355		10a
11	Activities	61,270	1,546	3,361	66,177	116	66,293		66,293		11
12	Social Services	46,605		387	46,992		46,992		46,992		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* related party							3,348	3,348		15
16	TOTAL Health Care and Programs	1,654,827	148,235	26,046	1,829,108	(25,627)	1,803,481	27,825	1,831,306		16
	C. General Administration										
17	Administrative	105,930			105,930		105,930	62,522	168,452		17
18	Directors Fees										18
19	Professional Services			428,903	428,903		428,903	(396,376)	32,527		19
20	Dues, Fees, Subscriptions & Promotions			59,785	59,785		59,785	(50,565)	9,220		20
21	Clerical & General Office Expenses	119,493	15,383	87,990	222,866	(482)	222,384	172,803	395,187		21
22	Employee Benefits & Payroll Taxes			426,322	426,322	22,647	448,969		448,969		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,542	1,542		1,542	504	2,046		24
25	Other Admin. Staff Transportation			499	499		499	9,299	9,798		25
26	Insurance-Prop.Liab.Malpractice			106,917	106,917		106,917	140	107,057		26
27	Other (specify):* related party			51,864	51,864		51,864	(19,570)	32,294		27
28	TOTAL General Administration	225,423	15,383	1,163,822	1,404,628	22,165	1,426,793	(221,243)	1,205,550		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,324,521	475,853	1,506,132	4,306,506	(30,307)	4,276,199	(241,319)	4,034,880		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			53,857	53,857		53,857	(1,148)	52,709			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			104,121	104,121		104,121	(38,530)	65,591			32
33	Real Estate Taxes			107,164	107,164		107,164	3,590	110,754			33
34	Rent-Facility & Grounds			419,268	419,268		419,268		419,268			34
35	Rent-Equipment & Vehicles			12,187	12,187		12,187	28,108	40,295			35
36	Other (specify):*											36
37	TOTAL Ownership			696,597	696,597		696,597	(7,980)	688,617			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		214,442	205,124	419,566	30,307	449,873	8,411	458,284			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			220,291	220,291		220,291		220,291			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		214,442	425,415	639,857	30,307	670,164	8,411	678,575			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,324,521	690,295	2,628,144	5,642,960		5,642,960	(240,888)	5,402,072			45

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

Reclassifications - Pages 3 & 4, Column 5

<u>From Line</u>	<u>To Line</u>	<u>Amount</u>	<u>Description</u>
2		(30,259)	Employee Meals
	22	30,259	Employee Meals
22		(7,612)	Uniforms
	1	1,376	Uniforms
	3	434	Uniforms
	4	524	Uniforms
	6	182	Uniforms
	10	4,564	Uniforms
	11	116	Uniforms
	21	416	Uniforms
10		(30,307)	Oxygen - to appropriate cost center
	39	30,307	Oxygen - to appropriate cost center
21		(898)	Vendor Settlement - Konic Elevator
	6	898	Vendor Settlement - Konic Elevator

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,699)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,513)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,131)	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	(11,408)	21		17
18	Fines and Penalties	(13,326)	32		18
19	Entertainment				19
20	Contributions	(4,394)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(27,333)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,864)	27		24
25	Fund Raising, Advertising and Promotional	(6,339)	20		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (129,007)		\$	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)	(12,428)	Various	34
35	Other- Attach Schedule	(99,453)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (111,881)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (240,888)		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

STATE OF ILLINOIS
Alden Lincoln Rehab & Health Care Center

Page 5A

Report Period Beginning: ID# 0040709
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg12 <\$2,500	\$ (1,829)	30	1
2	Elim Deprec Exp on Pg13 <\$2,500	(8,978)	30	2
3	Expense Pg13 <\$2,500 - current year purch	8,079	6	3
4	Expense Pg12 <\$2,500	158	6	4
5				5
6	Elim ABC Pg12 - Related Party Profit 2008-2010	(19)	30	6
7	Elim ABC Pg12 - Related Party Profit 2011-2012	133	30	7
8				8
9	adjustment on depreciation expense	(65)	30	9
10				10
11	Late Fees on Utilities	(1,083)	5	11
12	Intercompany Interests	(89,307)	32	12
13				13
14	Miscellaneous Income - Food Rebate	(1,903)	2	14
15	Miscellaneous Income - Poll site	(300)	6	15
16	Miscellaneous Income - Medical records	(334)	10	16
17	back out Marketing Manager salaries 6701-100-009	none for 2012		17
18	back out employee benefit -Marketing Manager	none for 2012		18
19	back out IHCA PAC Fees (30%)	(1,590)	20	19
20	Deming Leadership Training (20%)	none for 2012		20
21	add back prior year Real Estate Tax Refund	none for 2012		21
22	other Nursing Home	(16)	21	22
23	back out Chamber of Commerce dues (6825)	none for 2012		23
24	back out Legal Fees - Group Midcap charge	(799)	19	24
25	back out Accounting Fees - Group Midcap charge	(1,250)	19	25
26	back out Lake View Chamber of Comm dues (6825)	(350)	20	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	(99,453)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center

0040709

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	2,878	(9,478)	0	0	0	0	0	0	0	(6,600)	1
2	Food Purchase	(3,034)	0	0	(45,173)	0	0	0	0	0	0	0	(48,207)	2
3	Housekeeping	0	0	3,217	0	0	0	0	0	0	0	0	3,217	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,083)	0	1,828	0	0	0	0	0	0	0	0	745	5
6	Maintenance	3,238	0	(7,557)	0	0	0	2,513	0	0	0	0	(1,806)	6
7	Other (specify):*	0	0	3,573	1,177	0	0	0	0	0	0	0	4,750	7
8	TOTAL General Services	(879)	0	3,939	(53,474)	0	0	2,513	0	0	0	0	(47,901)	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	(334)	0	22,949	84	1,778	0	0	0	0	0	0	24,477	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	3,348	0	0	0	0	0	0	0	0	3,348	15
16	TOTAL Health Care and Programs	(334)	0	26,297	84	1,778	0	0	0	0	0	0	27,825	16
	C. General Administration													
17	Administrative	0	0	62,522	0	0	0	0	0	0	0	0	62,522	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(29,382)	0	(366,994)	0	0	0	0	0	0	0	0	(396,376)	19
20	Fees, Subscriptions & Promotions	(12,673)	0	(37,892)	0	0	0	0	0	0	0	0	(50,565)	20
21	Clerical & General Office Expenses	(11,424)	0	145,663	21,207	17,357	0	0	0	0	0	0	172,803	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	504	0	0	0	0	0	0	0	0	504	24
25	Other Admin. Staff Transportation	0	0	9,299	0	0	0	0	0	0	0	0	9,299	25
26	Insurance-Prop.Liab.Malpractice	0	0	140	0	0	0	0	0	0	0	0	140	26
27	Other (specify):*	(51,864)	0	28,669	2,416	1,209	0	0	0	0	0	0	(19,570)	27
28	TOTAL General Administration	(105,343)	0	(158,089)	23,623	18,566	0	0	0	0	0	0	(221,243)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,556)	0	(127,853)	(29,767)	20,344	0	2,513	0	0	0	0	(241,319)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
(to Sch V, col.7)														
30	Depreciation	(10,758)	0	9,610	0	0	0	0	0	0	0	0	(1,148)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(111,146)	0	72,499	0	117	0	0	0	0	0	0	(38,530)	32
33	Real Estate Taxes	0	0	3,419	0	171	0	0	0	0	0	0	3,590	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	28,108	0	0	0	0	0	0	0	0	28,108	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(121,904)	0	113,636	0	288	0	0	0	0	0	0	(7,980)	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	(18,775)	(7,631)	34,817	0	0	0	0	0	8,411	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	(18,775)	(7,631)	34,817	0	0	0	0	0	8,411	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(228,460)	0	(14,217)	(48,542)	13,001	34,817	2,513	0	0	0	0	(240,888)	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.

1OWNERS		2RELATED NURSING HOMES		3OTHER 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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 1,828	\$ 1,828	15
16	V	24 Travel and Seminar		Alden Management Services, Inc.		504	504	16
17	V	25 Other Admin Travel		Alden Management Services, Inc.		9,299	9,299	17
18	V	26 Insurance		Alden Management Services, Inc.		140	140	18
19	V	20 Dues and Subscription	39,348	Alden Management Services, Inc.		1,456	(37,892)	19
20	V	30 Depreciation		Alden Management Services, Inc.		9,610	9,610	20
21	V	33 Real estate taxes		Alden Management Services, Inc.		3,419	3,419	21
22	V	35 Rent - Equipment & Vehic		Alden Management Services, Inc.		28,108	28,108	22
23	V	32 Interest		Alden Management Services, Inc.		72,499	72,499	23
24	V	1 Dietary		Alden Management Services, Inc.		2,878	2,878	24
25	V	3 Housekeeping		Alden Management Services, Inc.		3,217	3,217	25
26	V	7 Employee Benefit - Gen Services		Alden Management Services, Inc.		3,573	3,573	26
27	V	10 Nurse & Medical Records Salary		Alden Management Services, Inc.		22,949	22,949	27
28	V	15 Employee Benefit - Health Care		Alden Management Services, Inc.		3,348	3,348	28
29	V	17 Administrative Salary		Alden Management Services, Inc.		62,522	62,522	29
30	V	27 Employee Benefit - Admin		Alden Management Services, Inc.		28,669	28,669	30
31	V	19 Professional Fee	388,695	Alden Management Services, Inc.		21,701	(366,994)	31
32	V	21 General and Administrative		Alden Management Services, Inc.		145,663	145,663	32
33	V	6 Repairs and Maintenance	38,633	Alden Management Services, Inc.		31,076	(7,557)	33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 466,676			\$ 452,459	\$ * (14,217)	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	\$ 22,800	Prism Health Care Sevices, Inc.	0.00%	\$ 97	\$ (22,703)	15
16	V	1	Diet Salary		Prism Health Care Sevices, Inc.		13,225	13,225	16
17	V	2	Tube Feeding	77,134	Prism Health Care Sevices, Inc.		31,961	(45,173)	17
18	V	10	Equipment Rental	6,660	Prism Health Care Sevices, Inc.		6,744	84	18
19	V	39	Ancillary Supplies	35,809	Prism Health Care Sevices, Inc.		17,034	(18,775)	19
20	V	21	Salary - G & A		Prism Health Care Sevices, Inc.		14,743	14,743	20
21	V	27	Employee Benefit		Prism Health Care Sevices, Inc.		2,416	2,416	21
22	V	7	Employee Benefit		Prism Health Care Sevices, Inc.		1,177	1,177	22
23	V	21	General and Administrative		Prism Health Care Sevices, Inc.		6,464	6,464	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			\$ 142,403			\$ 93,861	\$ * (48,542)	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	\$ 120,482	Forum Extended Care Services II, Inc.	0.00%	\$ 153,919	\$ 33,437	15
16	V	39	IV	45,422			5,642	(39,780)	16
17	V	39	Wound Care	6,262			4,974	(1,288)	17
18	V	10	House Stock	7,059			6,530	(529)	18
19	V	10	Pharmacy Consultant	2,305			4,612	2,307	19
20	V	27	Employee Vaccination	694			551	(143)	20
21	V	27	Employee Benefit: G & A				1,352	1,352	21
22	V	21	Salary: G & A				9,874	9,874	22
23	V	21	General and Administrative				7,483	7,483	23
24	V	32	Interest				117	117	24
25	V	33	Real Estate Tax				171	171	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			\$ 182,224			\$ 195,225	\$ * 13,001	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	\$ 200,538	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 235,355	\$ 34,817	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			\$ 200,538			\$ 235,355	\$ * 34,817	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	\$ 40,703	Alden Bennett Construction Company, Inc.	0.00%	\$ 43,216	\$ 2,513	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			\$ 40,703			\$ 43,216	\$ * 2,513	39

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President	CEO	100.00	181,059	0.852	2.13	Salary	\$ 3,941	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	66,998	0.852	2.13	Salary	1,462	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,678	0.852	2.13	Salary	842	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	\$ 6,245		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center # 0040709 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,340,098	35	\$ 85,836	\$	28,547	\$ 1,828	1
2	24	Travel and Seminar	Patient Days	1,340,098	35	23,644		28,547	504	2
3	25	Other Admin Travel	Patient Days	1,340,098	35	436,530		28,547	9,299	3
4	26	Insurance	Patient Days	1,340,098	35	6,589		28,547	140	4
5	20	Dues and Subscription	Patient Days	1,340,098	35	68,371		28,547	1,456	5
6	30	Depreciation	No of providers/usage	35	35	340,112		1	9,610	6
7	33	Real Estate taxes	Patient Days	1,340,098	35	184,769		28,547	3,419	7
8	35	Rent - Equipment & Vehic	Patient Days	1,340,098	35	1,319,497		28,547	28,108	8
9	32	Interest	Patient Days	1,340,098	35	2,398,912		28,547	72,499	9
10	1	Dietary	Patient Days	1,340,098	35	135,080	135,080	28,547	2,878	10
11	3	Housekeeping	Patient Days	1,340,098	35	151,028	151,028	28,547	3,217	11
12	7	Employee Benefit - Gen Services	Patient Days	1,340,098	35	167,731		28,547	3,573	12
13	10	Nurse & Medical Records Salary	Patient Days	1,340,098	35	1,186,643	1,186,643	28,547	22,949	13
14	15	Employee Benefit - Health Care	Patient Days	1,340,098	35	157,190		28,547	3,348	14
15	17	Administrative Salary	Patient Days	1,340,098	35	3,283,025	3,283,025	28,547	62,522	15
16	27	Employee Benefit - Admin	Patient Days	1,340,098	35	1,345,837		28,547	28,669	16
17	19	Professional Fee	Patient Days	1,340,098	35	1,018,709	751,716	28,547	21,701	17
18	21	General and Administrative	Patient Days	1,340,098	35	6,837,958	6,125,097	28,547	145,663	18
19	6	Repairs and Maintenance	Patient Days	1,340,098	35	1,458,765	980,107	28,547	31,076	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 20,606,226	\$ 12,612,696		\$ 452,459	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							\$	\$			\$	1	
2												2	
3												3	
4												4	
5	Medical Malpractice Insurance										1,487	5	
	Working Capital												
6	Related party-AMS		x								72,499	6	
7	Related party-FECII		x								117	7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 74,103	9	
	B. Non-Facility Related*												
10	Interest Income (GL 4646/4975)										(8,512)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (8,512)	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 65,591	15	

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

* 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 2011 report.		\$	111,400	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.)		\$	107,664	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,736)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	110,900	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.		\$	107,164	7	
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax		\$	3590
		Total Real Estate Tax Expense, Sch V, Line 33		\$	110,754
Real Estate Tax Bill for Calendar Year:		2007	107,389	8	
		2008	108,466	9	
		2009	103,604	10	
		2010	108,114	11	
		2011	107,664	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 2011	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION	16

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

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Alden Lincoln Rehab & Health Care Center

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0040709

CONTACT PERSON REGARDING THIS REPORT
Steven M. Kroll

TELEPHONE
773-286-3883

FAX #:
773-286-8038

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. See attached (Supplement)	Related party-Alden Management	\$ 303,210.00	\$ 3,419.00
2. See attached (Supplement)	Related party-Forum Ext. Care II	\$ 37,853.00	\$ 171.00
3. 11-28-108-023-0000	Nursing Home Facility	\$ 107,664.46	\$ 107,664.46
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 448,727.46	\$ 111,254.46

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

A. Square Feet: 32,252

B. General Construction Type: Exterior brick Frame steel Number of Stories 3

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center

0040709

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler heads			1995	1,832	73	25	73		1,262	9
10	Roof repairs			1995	2,000		10			2,000	10
11	Installed Electric AMPS			1996	1,870		5			1,870	11
12	Signs			1996	1,800		10			1,800	12
13	Water Heater			1997	6,180		5			6,180	13
14	Replace Pipes			1997	5,949		5			5,949	14
15	Exhaust Fans			1997	8,403		5			8,403	15
16	Washing machine motor			1998	1,576		8			1,576	16
17	ABC (General construction) Major repairs/improvement			1999	5,713		10			5,713	17
18	ABC (General construction) Major repairs/improvement			1999	2,326		10			2,326	18
19	ABC (General construction) Major repairs/improvement			1999	2,092		10			2,092	19
20	ABC (General construction) Major repairs/improvement			1999	1,870		10			1,870	20
21	ABC (General construction) Major repairs/improvement			1999	12,658		10			12,658	21
22	ABC (General construction) Major repairs/improvement			1999	2,250		10			2,250	22
23	ABC (General construction) Major repairs/improvement			1999	10,225		10			10,225	23
24	Climate Services (exhaust fan)			1999	2,280		5			2,280	24
25	Oxygen exhaust system			2000	8,555		8			8,555	25
26	Elevator door repair			2000	1,518		5			1,518	26
27	Lawn Sprinkler			2000	15,500	620	25	620		7,647	27
28	ABC (General construction) Major repairs/improvement			2000	6,937		5			6,937	28
29	ABC (General construction) New hot water system			2000	49,596	2,480	20	2,480		31,826	29
30	ABC (General construction) Replace showers			2000	23,903		10			23,903	30
31	Replace Fire Pump			2001	3,230	162	20	162		1,942	31
32	14 Kilowatt water heater booster			2001	2,783		10			2,783	32
33	ABC (General construction) Major repairs/improvement			2001	3,402		5			3,402	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 Lincoln Rehab & Health Care Center

0040709

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Capps Plumbing (pipe & wall repair)	2002	\$ 1,985	\$	5	\$	\$	\$ 1,985	37
38	ABC (misc construction work)	2002	3,442		5			3,442	38
39	ABC (repair ejector pump)	2002	7,893		5			7,893	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		1,708	40
41	TNS (DSL Cable)	2004	1,358		5			1,358	41
42	ABC (1st Floors Stairs)	2004	1,699	170	10	170		1,374	42
43	Oak Fire security System, new base dual zone card	2005	1,350		5			1,350	43
44	Washtown (repair Washer motor)	2005	1,563		5			1,563	44
45	ABC (repair Mop basin)	2005	1,613		5			1,613	45
46	ABC - seal holes and replace fill materials 3rd floor	2006	5,793	579	10	579		3,908	46
47	TopNotch - booster heater	2006	3,217	322	10	322		2,012	47
48	ABC - wall covering	2007	10,494	1,049	10	1,049		5,945	48
49	ABC - HM door and frame	2008	3,270	327	10	327		1,526	49
50	Central States - sprinkler system	2008	3,700	740	5	740		2,960	50
51	ABC - patio door	2008	2,501	250	10	250		1,063	51
52	ABC - repair electrical room and patio doors	2008	2,915	292	10	292		1,192	52
53	JD Roofing - asphalt roof patched	2009	3,600	360	10	360		1,200	53
54	Oak Fire - wirings for sprinkler system	2009	5,070	507	10	507		1,817	54
55	ABC - roof replaced	2010	3,886	389	10	389		908	55
56	ABC - elevator	2010	66,555	3,328	20	3,328		6,933	56
57	Rockford - railings repaired	2010	4,440	444	10	444		1,110	57
58									58
59	Elevator cylinder replacement - South elevator - ABC	2011	14,809	740	20	740		925	59
60	Pipes boiler room repair - ABC	2011	7,669	383	20	383		415	60
61	Pump, main circuit boiler, Grease trap - ABC	2011	5,097	1,019	5	1,019		1,189	61
62	Pump, main controller - ABC	2011	3,828	383	10	383		447	62
63	Kone - elevator, motor soft starter	2012	13,882	521	20	521		521	63
64	ABC - fence and guard rails	2012	5,080	254	15	254		254	64
65	ABC - railings	2012	5,491	244	15	244		244	65
66	ABC - Boiler Pacific	2012	7,225	211	20	211		211	66
67	ABC - fire alarm system	2012	18,456	1,077	10	1,077		1,077	67
68	ABC - boiler leak	2012	6,605	330	10	330		330	68
69	GT Mech - fire dampers	2012	4,632	116	10	116		116	69
70	TOTAL (lines 4 thru 69)		\$ 416,841	\$ 17,533		\$ 17,533	\$	\$ 215,556	70

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

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center

0040709

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 416,841	\$ 17,533		\$ 17,533	\$	\$ 215,556	1
2	Forum Prof Ctr: Remodeling	1979	15,057		20			15,057	2
3	Forum Prof Ctr: Build Improv - multiple	1980	29,324		15			29,324	3
4	Forum Prof Ctr: Tennant Improv	1986	925		13			925	4
5	Forum Prof Ctr: AMS remodel	1990	6,289		10			6,289	5
6	Forum Prof Ctr: Roof	1994	3,317		16			3,317	6
7	Forum Prof Ctr: Build Improv-multiple	1995	1,170	73	16	73		1,170	7
8	Forum Prof Ctr: Asphalt/Design/etc.	2000	1,848	14	10	14		1,816	8
9	Forum Prof Ctr: Remodel/electrical	2001	720	26	7	26		694	9
10	Forum Prof Ctr: bathroom remodel	2002	637	45	5	45		637	10
11	Forum Prof Ctr: remodel suites/etc.	2003	818	81	9	81		818	11
12	Forum Prof Ctr: lunchroom/suites remodel/concrete/plaster/etc	2004	2,519	101	7	101		2,291	12
13	Forum Prof Ctr: Suite renovation	2005	509	(12)	10	(12)		590	13
14	Forum Prof Ctr: Superior installations, etc.	2006	121		4			121	14
15	Forum Prof Ctr: Sidewalks/major hvac/Condensor	2007	489	59	7	59		389	15
16	Forum Prof Ctr: Park. Lot/glass/maj hvac	2008	420	51	7	51		284	16
17	Forum Prof Ctr: Maj Hvac/re-stucco bldg	2009	854	82	7	82		264	17
18	Forum Prof Ctr: Building Renovations	2010	1,455	295	7	295		676	18
19	Forum Prof Ctr: Building Renovations	2011	6,379	648	7	648		802	19
20	Forum Prof Ctr: Building Renovations	2012	278	38	7	38		38	20
21	Alden Mgt Servs: Remodel suites	1993	6,764		7			6,764	21
22	Alden Mgt Servs: Remodel suites	2002	282		7			282	22
23	Alden Mgt Servs: Remodel suites	2003	6,115		7			6,115	23
24									24
25									25
26	Adjust for ABC Related Party Profit	2008	(50)	(8)		(8)		(26)	26
27	Adjust for ABC Related Party Profit	2009	(161)	(6)		(6)		(18)	27
28	Adjust for ABC Related Party Profit	2010	(862)	(5)		(5)		(15)	28
29	Adjust for ABC Related Party Profit	2011	293	2		2		3	29
30	Adjust for ABC Related Party Profit	2012	2,646	131		131		131	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 504,997	\$ 19,148		\$ 19,148	\$	\$ 294,295	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	\$227,735	\$28,474	\$28,474	\$	various	\$112,820	71
72	Current Year Purchases	59,034	3,384	3,384		various	3,384	72
73	Fully Depreciated Assets	224,210	1,703	1,703		various	224,210	73
74								74
75	TOTALS	\$510,979	\$33,561	\$33,561	\$		\$340,414	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				\$	\$	\$	\$		\$	76
77										77
78										78
79	Related Party - AMS	various	98-02	3,911				3	3,911	79
80	TOTALS			\$3,911	\$	\$	\$		\$3,911	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,019,887	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$52,709	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$52,709	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)	\$638,620	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	Building Improvements	11,418	93
94			94
95		\$11,418	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: T.L. Enterprises, Inc.
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:		96		\$ 419,909	4	6	3
4	Additions							4
5								5
6								6
7	TOTAL		96		\$ 419,909			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: Payment of \$448,817 exercisable a *

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: \$ 31,409
- Description: copy machine (GL 6861) and office equipment (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	\$ #####	\$ 14,097	17
18					18
19	Auto Lease GL 6890	various	0.00		19
20					20
21	TOTAL		\$ #####	\$ 14,097	21

10. Effective dates of current rental agreement:

Beginning10/26/2012

Ending02/28/2017

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

	Fiscal Year Ending	Annual Rent
12.	12/31/13	\$ 393,902
13.	12/31/14	\$ 400,480
14.	12/31/15	\$ 400,480

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

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

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

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	\$		\$ 83,660	\$		\$ 83,660	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			16,957			16,957	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			99,921			99,921	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				153,919		153,919	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39-1,39-3								12
13	Other (specify): <u>See Pg 16A</u>					34,817	69,010		103,827	13
14	TOTAL			\$		\$ 235,355	\$ 222,929		\$ 458,284	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
XIV. Special Services (Direct Cost)	Col 6: Supplies

Line	Service	Col. 1:	Ref. No.	To Pg 16:	Col. No.	
1.	OT		39-3	To Col 5		\$83,660.00
2.	ST		39-3	To Col 5		16,957.00
3.						
4.	PT		39-3	To Col 5		99,921.00
5.						
6.						
7.						
8.						
	Pharmacy Supplies per GL					120,482.00
	Manual Input from Related Party- Forum Drugs					33,437.00
9.	Total to line 9 Pharmacy	See Pg 16A		To Col 6		153,919.00
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		34,817.00
	Other					98,546.00
	HFS 3745 (N-4-99)					

Manual Input: Related Party - Prism		(18,774.00)
Manual Input: Related Party FECII - I.V.		(39,781.00)
Manual Input: Related Party FECII - Wound Care		(1,288.00)
Oxygen, from reclass worksheet (Pg 4A)		30,307.00

13. Col 6: Supplies Total	To Col 6	69,010.00

13. Total Line 13, Column 8		103,827.00

14. Total		458,284.00
		=====

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 105,000)	1,357,354		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,557		7
8	Accounts Receivable (owners or related parties)	3,996		8
9	Other(specify): Due from 3rd parties			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,366,907	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	520,442		15
16	Equipment, at Historical Cost	494,913		16
17	Accumulated Depreciation (book methods)	(613,396)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	239,883		21
22	Other Long-Term Assets (spec Purchase Option/CIP	299,418		22
23	Other(specify): Due from affiliates			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 941,260	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,308,167	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 472,590	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	64,012		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	238,545		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,474		31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,900		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp,Due HFS,SalesTax,Etc.	125,169		36
37	Due to affiliates/3rd Parties	731,109		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,780,799	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliates	1,784,413		43
44	S/holder loans, others			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,784,413	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,565,212	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,257,045)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,308,167	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (859,678)	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded		3
4	after prior year report submitted:	171,259	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (688,419)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(568,626)	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)	\$ (568,626)	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)	\$ (1,257,045)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center# 0040709Report Period Beginning: 01/01/2012Ending: 12/31/2012**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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,942,169	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,942,169	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,225	6
7	Oxygen	34,197	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 118,422	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	128	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	2,565	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,513	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,513	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See PG19A</u>	2,537	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,537	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,074,334	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,072,770	31
32	Health Care	1,829,108	32
33	General Administration	1,404,628	33
	B. Capital Expense		
34	Ownership	696,597	34
	C. Ancillary Expense		
35	Special Cost Centers	419,566	35
36	Provider Participation Fee	220,291	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,642,960	40
41	Income before Income Taxes (line 30 minus line 40)**	(568,626)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (568,626)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Medicaid</u>	3,273,900	47
48	Other-(specify) <u>Medicare/Private/Veterans/Hospice/Insurance</u>	1,668,269	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,942,169	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Facility Name & ID Number Alden Lincoln Rehab & Health Care Center# 0040709

Report Period Beginning 01/01/2012 Ending:

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Medical Records	\$ 334
Jury Jury	\$ -
Food Rebate	\$ 1,903
Poll Site	\$ 300

Line 28 Total:	<u><u>2,537</u></u>
----------------	---------------------

12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 75,000	\$ 36.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,942	9,493	265,130	27.93	3
4	Licensed Practical Nurses	18,546	19,852	509,194	25.65	4
5	CNAs & Orderlies	44,210	48,505	546,285	11.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,600	1,668	26,840	16.09	9
10	Activity Assistants	3,591	3,765	34,430	9.14	10
11	Social Service Workers	2,080	2,080	46,605	22.41	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	48,443	23.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,468	15,713	165,176	10.51	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	69,218	33.28	17
18	Housekeepers	9,780	10,563	111,112	10.52	18
19	Laundry	3,699	4,575	50,321	11.00	19
20	Administrator	1,928	2,088	84,776	40.60	20
21	Assistant Administrator	880	880	21,154	24.04	21
22	Other Administrative	3,880	3,983	110,815	27.82	22
23	Office Manager	2,080	2,080	36,952	17.77	23
24	Clerical	2,528	2,632	24,860	9.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,672	1,826	62,018	33.96	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Alz.Direct.	2,040	2,078	36,192	17.42	33
34	TOTAL (lines 1 - 33)	128,164	138,021	\$ 2,324,521 *	\$ 16.84	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	1900/month	\$ 22,800	1-3	35
36	Medical Director	875/month	10,500	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192/month	2,304	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	256/month	3,081	11-3	44
45	Social Service Consultant	1 month	280	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,965		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.

STATE OF ILLINOIS

Facility Name & ID Number

Alden Lincoln Rehab & Health Care Center

0040709

Report Period Beginning: 01/01/2012

Page 21

Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Carrie Groulx

Administrator

0

\$ 84,776

Allison Pease

Assistant Administratot

0

21,154

0

0

0

0

0

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 105,930

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 Servs.

Consulting

\$ 350,883

AMS (Eliminated)

Allocated Legal Fees

37,812

BDO Seidman

Tax Preparation

1,892

BT/Virchow Krause/KPMG/Ava Dal

Accounting Fees

4,114

First Advantage

Tax Services

624

Ken Fisch

Legal Fees - Collections

27,333

Linda Roberts & Associates

Food Service Audit

568

Alden Group (Eliminated)

Accounting Fees

1,250

Alden Group (Eliminated)

Legal Fees - Non Collection

799

KPMG/Ava Daly

Accounting Fees

217

Jackson Lewis

Union Issue

294

Schmidt Salzman/Urban Real Estate

Tax Services

3,117

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 428,903

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 72,631

Unemployment Compensation Insurance

27,677

FICA Taxes

175,744

Employee Health Insurance

41,436

Employee Meals

30,259

Illinois Municipal Retirement Fund (IMRF)*

Union, Health & Welfare

60,560

Dental & Life

928

Pension

17,924

Employee Relations/Misc Payroll Costs

1,448

Drug Tests/Vaccinations

2,454

401k Match/Tuition Reimbursement

15,934

Chicago Head Tax

1,974

TOTAL (agree to Schedule V, line 22, col.8)

\$ 448,969

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

253

Health Care Worker Background Check

(Indicate # of checks performed 78)

780

Patient Background Checks

27

816

Surety Bond Fee

600

IL Health Care Association

4,710

Collaborative Healthcare

580

Secretary of State

25

Related party- AMS

1,456

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 9,220

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Related party- AMS

504

Seminar Expense

IL Health Care Associations-Administrator

976

IL Council of Long Term Care

210

Foundations for Educ/NIC for Senior Care

356

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 2,046

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Legal Fee Support	
Legal Fees Reported on Pg 21, Section C:	28,132.00
Less: Collection, estates & other non-allowable legal fees listed on Pg 5, Ln 19	(27,333.00)
Less: Non-allowable legal fees, if any, deducted on Pg 5A	<u>(799.00)</u>
Allowable Legal Fees	<u><u>-</u></u>

NOTE:
Legal invoices are not required to be submitted this year because the amount is below \$5,000.

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	Climate Service - boil	1/96	2,015	15	134	134	134	134					
2	Great Lakes - plumbing fi	3/96	1,739	20	87	87	87	87	87	87	87	87	87
3	Building Plumbing Heat	10/96	1,831	15	122	122	122	122	30				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,585		\$ 343	\$ 343	\$ 343	\$ 343	\$ 117	\$ 87	\$ 87	\$ 87	\$ 87

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.

IL Health Care Associations \$5,299
- (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.

\$ 28,192

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

x

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

x

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 220,291

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.

\$ 30,259

Has any meal income been offset against related costs?

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 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.