

		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>0049122</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Alden Village North</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>7464 N. Sheridan Road</u> <u>Chicago</u> <u>60626</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>773-338-0200</u> Fax # <u>773-338-5122</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Joan Carl</u></td></tr><tr><td>(Title) <u>Vice-President</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Joan Carl</u>	(Title) <u>Vice-President</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630											
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	(Telephone) <u>()</u> Fax # <u>()</u>																								
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																								
Date of Initial License for Current Owners: <u>1/3/08</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:																									
Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>																									
Email Address: _____																									

Facility Name & ID Number Alden Village North# 0049122 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)		0	1
2	150	Skilled Pediatric (SNF/PED)	150	54,900	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	54,900	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	24,788	393	0	25,181	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,788	393		25,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 45.87%

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

342 (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 1/3/08

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

YES ☒Date 1/3/08NO ☐

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

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary Not Applicable

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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	251,970	19,910	22,800	294,680	7,536	302,216	(6,940)	295,276			1
2	Food Purchase		381,339		381,339	(29,741)	351,598	(168,258)	183,340			2
3	Housekeeping	111,223	45,705		156,928	6,701	163,629	2,838	166,467			3
4	Laundry	141,572	22,120		163,692		163,692		163,692			4
5	Heat and Other Utilities			167,610	167,610		167,610	(9)	167,601			5
6	Maintenance	45,248		161,459	206,707	(581)	206,126	28,137	234,263			6
7	Other (specify):* related party / security			28	28		28	5,880	5,908			7
8	TOTAL General Services	550,013	469,074	351,897	1,370,984	(16,085)	1,354,899	(138,352)	1,216,547			8
	B. Health Care and Programs											
9	Medical Director			45,125	45,125		45,125		45,125			9
10	Nursing and Medical Records	2,710,697	144,946	12,410	2,868,053	(23,546)	2,844,507	22,913	2,867,420			10
10a	Therapy					333,590	333,590	24,035	357,625			10a
11	Activities	67,870	5,022	133,661	206,553	840	207,393		207,393			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* related party							2,954	2,954			15
16	TOTAL Health Care and Programs	2,778,567	149,968	191,196	3,119,731	310,884	3,430,615	49,902	3,480,517			16
	C. General Administration											
17	Administrative	110,385			110,385		110,385	99,601	209,986			17
18	Directors Fees											18
19	Professional Services			320,528	320,528	(12,830)	307,698	(194,205)	113,493			19
20	Dues, Fees, Subscriptions & Promotions			31,767	31,767		31,767	(20,314)	11,453			20
21	Clerical & General Office Expenses	206,748	14,097	43,908	264,753	1,713	266,466	189,559	456,025			21
22	Employee Benefits & Payroll Taxes			722,993	722,993	10,333	733,326		733,326			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,306	2,306		2,306	444	2,750			24
25	Other Admin. Staff Transportation			9,511	9,511		9,511	8,203	17,714			25
26	Insurance-Prop.Liab.Malpractice			157,986	157,986		157,986	124	158,110			26
27	Other (specify):* related party / bad debt			52,985	52,985		52,985	(21,884)	31,101			27
28	TOTAL General Administration	317,133	14,097	1,341,984	1,673,214	(784)	1,672,430	61,528	1,733,958			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,645,713	633,139	1,885,077	6,163,929	294,015	6,457,944	(26,922)	6,431,022			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			52,159	52,159		52,159	485,891	538,050			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,846	12,846	118	12,964	770,023	782,987			32
33	Real Estate Taxes			107,658	107,658	(107,658)		110,684	110,684			33
34	Rent-Facility & Grounds			1,099,707	1,099,707	107,658	1,207,365	(1,207,365)				34
35	Rent-Equipment & Vehicles			16,164	16,164		16,164	24,794	40,958			35
36	Other (specify):* Mortgage Insurance							109,007	109,007			36
37	TOTAL Ownership			1,288,534	1,288,534	118	1,288,652	293,034	1,581,686			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,948	306,312	434,260	(294,133)	140,127	(16,317)	123,810			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			357,700	357,700		357,700		357,700			42
43	Other (specify):* Day Training			538,310	538,310		538,310		538,310			43
44	TOTAL Special Cost Centers		127,948	1,202,322	1,330,270	(294,133)	1,036,137	(16,317)	1,019,820			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,645,713	761,087	4,375,933	8,782,733		8,782,733	249,795	9,032,528			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		(29,741)	Employee Meals
	22	29,741	Employee Meals
22		(19,408)	Uniforms
	1	7,536	Uniforms
	3	6,701	Uniforms
	4	-	Uniforms
	6	-	Uniforms
	10	3,921	Uniforms
	11	-	Uniforms
	21	1,250	Uniforms
10		(39,457)	Oxygen - to appropriate cost center
	39	39,457	Oxygen - to appropriate cost center
33		(107,658)	Rent - Real Estate Tax on associated landowner (Pg 6)
	34	107,658	Rent - Real Estate Tax on associated landowner (Pg 6)
21		463	Vendor Settlements
	6	(463)	Vendor Settlements (may effect more than one line)
39		(306,312)	PT, OT, ST, & RT Therapy Costs (Pg 16 related
	10a	306,312	PT, OT, ST, & RT Therapy Costs (Pg 16 related
39		(27,278)	Vent Supplies (related to RT, Pg 16)
	10a	27,278	Vent Supplies (related to RT, Pg 16)
19		(11,990)	Clinical Coordinators (Pathway Billing)
	10	11,990	Clinical Coordinators (Pathway Billing)

32		118	Maintenance Expense Adj Mis-posted to interest
	6	(118)	Maintenance Expense Adj Mis-posted to interest
19		(840)	Reclass mis-posted activity consultant
	11	840	Reclass mis-posted activity consultant
Net		-	

		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	(4,219)	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	(183)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(157)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,188)	21		17
18	Fines and Penalties	(10,790)	32		18
19	Entertainment	(2,900)	20		19
20	Contributions	(7,370)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,238)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,985)	27		24
25	Fund Raising, Advertising and Promotional	(8,295)	20		25
26	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)	\$ (90,325)		\$	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)	326,138	Various	34
35	Other- Attach Schedule	13,982	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 340,120		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 249,795		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Village North

ID# 0049122

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Elim Deprec Exp on Pg 12 items under \$2,500 -	\$ (4,132)	30	1
2	Elim Deprec Exp on Pg 13 items under \$2500 -	(11,290)	30	2
3	Expense Pg 12 items under \$2,500 - curr yr purchs +	4,231	6	3
4	Expense Pg 13 items under \$2,500 - curr yr purchs +	11,092	6	4
5				5
6	Elim ABC Deprec Exp from Pg 12 series -	(152)	30	6
7				7
8	Utility Late Fees	(1,622)	5	8
9	Other Nursing Income (Flu shots)	(160)	21	9
10	Misc Income-Jury Duty	(34)	21	10
11	Misc Income-Polling Site Reimbursement	(300)	21	11
12	Misc Income-Record Copies	(141)	10	12
13	Back out PAC fees - IHCA at 30%	(2,634)	20	13
14	Eliminate Chamber of Commerce contribution	(400)	20	14
15	Adj Real Estate Tax variance on bank statement	(30)	33	15
16	Add 2011 Legal Accrual Reversing-Bckd out in 2011	20,000	19	16
17	Back out 2011 legal invoice added to last yr report	(446)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	13,982		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Village North # 0049122 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	2,538	(9,478)	0	0	0	0	0	0	0	(6,940)	1
2	Food Purchase	(157)	0	0	(168,101)	0	0	0	0	0	0	0	(168,258)	2
3	Housekeeping	0	0	2,838	0	0	0	0	0	0	0	0	2,838	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,622)	0	1,613	0	0	0	0	0	0	0	0	(9)	5
6	Maintenance	11,104	0	15,033	0	0	0	2,000	0	0	0	0	28,137	6
7	Other (specify):*	0	0	3,152	2,728	0	0	0	0	0	0	0	5,880	7
8	TOTAL General Services	9,325	0	25,174	(174,851)	0	0	2,000	0	0	0	0	(138,352)	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	(141)	0	20,243	84	2,727	0	0	0	0	0	0	22,913	10
10a	Therapy	0	0	0	0	0	24,035	0	0	0	0	0	24,035	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	2,954	0	0	0	0	0	0	0	0	2,954	15
16	TOTAL Health Care and Programs	(141)	0	23,197	84	2,727	24,035	0	0	0	0	0	49,902	16
	C. General Administration													
17	Administrative	0	1,000	98,601	0	0	0	0	0	0	0	0	99,601	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	17,316	18,417	(229,938)	0	0	0	0	0	0	0	0	(194,205)	19
20	Fees, Subscriptions & Promotions	(21,599)	0	1,285	0	0	0	0	0	0	0	0	(20,314)	20
21	Clerical & General Office Expenses	(1,682)	9,484	128,488	49,147	4,122	0	0	0	0	0	0	189,559	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	444	0	0	0	0	0	0	0	0	444	24
25	Other Admin. Staff Transportation	0	0	8,203	0	0	0	0	0	0	0	0	8,203	25
26	Insurance-Prop.Liab.Malpractice	0	0	124	0	0	0	0	0	0	0	0	124	26
27	Other (specify):*	(52,985)	0	25,289	5,600	212	0	0	0	0	0	0	(21,884)	27
28	TOTAL General Administration	(58,950)	28,901	32,496	54,747	4,334	0	0	0	0	0	0	61,528	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,766)	28,901	80,867	(120,020)	7,061	24,035	2,000	0	0	0	0	(26,922)	29

STATE OF ILLINOIS

Facility Name & ID Number Alden Village North

0049122

Report Period Beginning:

01/01/2012 Ending:

Summary B
12/31/2012

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

	Capital Expense	PAGES	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	(15,574)	491,855	9,610	0	0	0	0	0	0	0	0	485,891	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,973)	776,308	4,660	0	28	0	0	0	0	0	0	770,023	32
33	Real Estate Taxes	(30)	107,657	3,016	0	41	0	0	0	0	0	0	110,684	33
34	Rent-Facility & Grounds	0	(1,207,365)	0	0	0	0	0	0	0	0	0	(1,207,365)	34
35	Rent-Equipment & Vehicles	0	0	24,794	0	0	0	0	0	0	0	0	24,794	35
36	Other (specify):*	0	109,007	0	0	0	0	0	0	0	0	0	109,007	36
37	TOTAL Ownership	(26,577)	277,462	42,080	0	69	0	0	0	0	0	0	293,034	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	(22,849)	6,532	0	0	0	0	0	0	(16,317)	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	(22,849)	6,532	0	0	0	0	0	0	(16,317)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(76,343)	306,363	122,947	(142,869)	13,662	24,035	2,000	0	0	0	0	249,795	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 1,207,365	Alden Village North II, LLC		\$	\$ (1,207,365)	1
2	V	32	Interest Income - Repl Reserve	49	Alden Village North II, LLC			(49)	2
3	V	17	Administrative		Alden Village North II, LLC		1,000	1,000	3
4	V	19	Professional Fees		Alden Village North II, LLC		18,417	18,417	4
5	V	33	Real Estate Tax		Alden Village North II, LLC		107,657	107,657	5
6	V	20	Dues & Subscriptions		Alden Village North II, LLC				6
7	V	32	Fines & Penalties		Alden Village North II, LLC				7
8	V	21	General Insurance		Alden Village North II, LLC		9,484	9,484	8
9	V	36	Mortgage Insurance Premium		Alden Village North II, LLC		109,007	109,007	9
10	V	32	Mortgage Interest		Alden Village North II, LLC		759,972	759,972	10
11	V	30	Depreciation		Alden Village North II, LLC		491,855	491,855	11
12	V	32	Amortization		Alden Village North II, LLC		16,385	16,385	12
13	V	21	Bank Fees		Alden Village North II, LLC				13
14	Total			\$ 1,207,414			\$ 1,513,777	\$ * 306,363	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%	\$ 1,613	\$ 1,613	15
16	V	24	Trav & Seminar		Alden Management Services, Inc.		444	444	16
17	V	25	Other Admin Travel		Alden Management Services, Inc.		8,203	8,203	17
18	V	26	Insurance		Alden Management Services, Inc.		124	124	18
19	V	20	Dues & Subscriptions		Alden Management Services, Inc.		1,285	1,285	19
20	V	30	Depreciation		Alden Management Services, Inc.		9,610	9,610	20
21	V	32	Amortization		Alden Management Services, Inc.				21
22	V	33	Real Estate Tax		Alden Management Services, Inc.		3,016	3,016	22
23	V	35	Rent -Equip & Vehicles		Alden Management Services, Inc.		24,794	24,794	23
24	V	32	Interest		Alden Management Services, Inc.		4,660	4,660	24
25	V	1	Dietary		Alden Management Services, Inc.		2,538	2,538	25
26	V	3	Housekeeping		Alden Management Services, Inc.		2,838	2,838	26
27	V	7	Employee Benefits -Gen'L Servs		Alden Management Services, Inc.		3,152	3,152	27
28	V	10	Nurs & Med Records Salary		Alden Management Services, Inc.		20,243	20,243	28
29	V	15	Employee Benefits -Health Care		Alden Management Services, Inc.		2,954	2,954	29
30	V	17	Administrative Salary		Alden Management Services, Inc.		98,601	98,601	30
31	V	27	Employee Benefits - Admin		Alden Management Services, Inc.		25,289	25,289	31
32	V	19	Professional Fees		Alden Management Services, Inc.		19,142	19,142	32
33	V	21	Gen'l & Admin		Alden Management Services, Inc.		128,488	128,488	33
34	V	6	Repair & Maint.	12,378	Alden Management Services, Inc.		27,411	15,033	34
35	V	19	Consulting & Legal	249,080	Alden Management Services, Inc.			(249,080)	35
36	V	6	Maintenance Allocation Charges		Alden Management Services, Inc.				36
37	V	20	Marketing Mgmt Fees		Alden Management Services, Inc.				37
38	V								38
39	Total			\$ 261,458			\$ 384,405	\$ * 122,947	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 Services, Inc.	0.00%	\$ 97	\$ (22,703)	15
16	V	1	Dietarty Salary		Prism Health Care Services, Inc.		13,225	13,225	16
17	V	2	Tube Feeding	230,011	Prism Health Care Services, Inc.		61,910	(168,101)	17
18	V	10	Equip. Rental	6,660	Prism Health Care Services, Inc.		6,744	84	18
19	V	39	Ancillary Supplies	70,546	Prism Health Care Services, Inc.		35,984	(34,562)	19
20	V	39	Vent Rental		Prism Health Care Services, Inc.		11,713	11,713	20
21	V	21	Gen'L & Admin Salary		Prism Health Care Services, Inc.		34,168	34,168	21
22	V	27	Employee Benefits		Prism Health Care Services, Inc.		5,600	5,600	22
23	V	7	Employee Benefits		Prism Health Care Services, Inc.		2,728	2,728	23
24	V	21	Gen'l & Admin		Prism Health Care Services, Inc.		14,979	14,979	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			\$ 330,017			\$ 187,148	\$ * (142,869)	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	\$ 26,339	Forum Extended Care Services II, Inc.	0.00%	\$ 33,649	\$ 7,310	15
16	V	39	IV		Forum Extended Care Services II, Inc.				16
17	V	39	Wound Care	3,785	Forum Extended Care Services II, Inc.		3,007	(778)	17
18	V	10	House Stock	9,215	Forum Extended Care Services II, Inc.		8,524	(691)	18
19	V	10	Pharmacy Consultant	3,413	Forum Extended Care Services II, Inc.		6,831	3,418	19
20	V	27	Employee Vaccin.	528	Forum Extended Care Services II, Inc.		419	(109)	20
21	V	27	Employee Benefits: G&A		Forum Extended Care Services II, Inc.		321	321	21
22	V	21	Gen'l & Admin. Salary		Forum Extended Care Services II, Inc.		2,345	2,345	22
23	V	21	Gen'l & Admin		Forum Extended Care Services II, Inc.		1,777	1,777	23
24	V	32	Interest		Forum Extended Care Services II, Inc.		28	28	24
25	V	33	Real Estate Tax		Forum Extended Care Services II, Inc.		41	41	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			\$ 43,280			\$ 56,942	\$ * 13,662	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	\$ 136,002	Community Physical Therapy & Associates, Ltd.	0.00%	\$ 160,037	\$ 24,035	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			\$ 136,002			\$ 160,037	\$ * 24,035	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	\$ 32,387	Alden Bennett Construction Company, Inc.	0.00%	\$ 34,387	\$ 2,000	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			\$ 32,387			\$ 34,387	\$ * 2,000	39

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

Facility Name & ID Number Alden Village North # 0049122 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

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	181,524	0.752	1.88	Salary	\$ 3,476	17-7	1
2	Lauren Magnusson	Dir. Of Clinical Servi	Technical Nursing	0.00	67,350	0.752	1.88	Salary	1,290	10-7	2
3	Terry Magnusson	Dir. of Purchasing	Supervise Mainten	0.00	38,777	0.752	1.88	Salary	743	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	\$ 5,509		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 Village North# 0049122

Report Period Beginning:

01/01/2012Ending: 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	1,340,098	35	\$ 85,836	\$	25,181	\$ 1,613	1
2	24	Trav & Seminar	Patient Days	1,340,098	35	23,644		25,181	444	2
3	25	Other Admin Travel	Patient Days	1,340,098	35	436,530		25,181	8,203	3
4	26	Insurance	Patient Days	1,340,098	35	6,589		25,181	124	4
5	20	Dues & Subscriptions	Patient Days	1,340,098	35	68,371		25,181	1,285	5
6	30	Depreciation	No of Providers/Usage	35	35	340,112		1	9,610	6
7	33	Real Estate Tax	Patient Days/Usage	1,340,098	35	184,769		25,181	3,016	7
8	35	Rent-Equip & Vehicle	Patient Days	1,340,098	35	1,319,497		25,181	24,794	8
9	32	Interest	Patient Days/Usage	1,340,098	35	2,398,912		25,181	4,660	9
10	1	Dietary	Patient Days	1,340,098	35	135,080	135,080	25,181	2,538	10
11	3	Housekeeping	Patient Days	1,340,098	35	151,028	151,028	25,181	2,838	11
12	7	Employee Benefits -Gen'I Servs	Patient Days	1,340,098	35	167,731		25,181	3,152	12
13	10	Nurs & Med Records Salary	Patient Days/Usage	1,340,098	35	1,186,643	1,186,643	25,181	20,243	13
14	15	Employee Benefits -Health Care	Patient Days	1,340,098	35	157,190		25,181	2,954	14
15	17	Administrative Salary	Patient Days/Usage	1,340,098	35	3,283,025	3,283,025	25,181	98,601	15
16	27	Employee Benefits - Admin	Patient Days	1,340,098	35	1,345,837		25,181	25,289	16
17	19	Professional fees	Patient Days	1,340,098	35	1,018,709	751,716	25,181	19,142	17
18	21	Gen'I & Admin	Patient Days	1,340,098	35	6,837,958	6,125,097	25,181	128,488	18
19	6	Repair & Maint.	Patient Days	1,340,098	35	1,458,765	980,107	25,181	27,411	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 20,606,226	\$ 12,612,696		\$ 384,405	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	\$ 12,841,749	7/1/2051	5.9000	\$ 759,972	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Related party-AMS		x	Working Capital							4,660	6							
7	Related party-FECII		x	Working Capital							28	7							
8	Related party-AMS		x	Malpractice Insurance Financing							2,174	8							
9	TOTAL Facility Related				\$70,406.00		\$ 12,960,000	\$ 12,841,749			\$ 766,834	9							
	B. Non-Facility Related*																		
10	Utility Deposit Interest Income										(47)	10							
11	Workers Comp Interest Income										(136)	11							
12	Amort of Fin Fees										16,385	12							
13	Interest Income on Repl Reserve										(49)	13							
14	TOTAL Non-Facility Related						\$	\$			\$ 16,153	14							
15	TOTALS (line 9+line14)						\$ 12,960,000	\$ 12,841,749			\$ 782,987	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 109,007 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 2011 report.		\$	111,700	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.)		\$	108,027	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,673)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	111,300	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.		\$	107,627	7	
Real Estate Tax History:		Plus: Related Party Taxes (2) - See Pg RE_Tax		\$	3,057
		Total Real Estate Tax Expense, Sch V, Line 33		\$	110,684
Real Estate Tax Bill for Calendar Year:		2007	101,192	8	
		2008	102,208	9	
		2009	103,953	10	
		2010	108,478	11	
		2011	108,027	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 Village North, Inc.

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
004-9122

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	\$ 3,016.00
2. See attached (Supplement)	Related Party-Forum Extended Care	\$ 37,853.00	\$ 41.00
3. 11-29-307-019-0000	7404 N. Sheridan Rd-Nursing Facility	\$ 24,743.83	\$ 24,743.83
4. 11-29-307-020-0000	7404 N. Sheridan Rd-Nursing Facility	\$ 23,871.19	\$ 23,871.19
5. 11-29-307-022-0000	7404 N. Sheridan Rd-Nursing Facility	\$ 59,411.99	\$ 59,411.99
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 449,090.01	\$ 111,084.01

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,814 **B. General Construction Type:** Exterior Load Bearing CMU, B 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

0049122

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	150		2008	1968	\$ 2,984,341	\$ 76,522	39	\$ 76,522	\$	\$ 382,610	4
5	Construction Project HUD 2009-2011			2011	6,830,905	175,151	39	175,151		306,515	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		2,949	9
10	ABC-Doors			2008	3,091	309	10	309		1,494	10
11	A&B Cable-Cable lines			2008	4,230	423	10	423		2,045	11
12	ABC-Remodel - plumbing			2008	4,635	927	5	927		4,249	12
13	ABC-Door entry system			2008	2,850	285	10	285		1,235	13
14	ABC-Hvac- major repair to system			2008	4,583	916	5	916		4,583	14
15	Capps-Drains - major repairs			2008	3,875	775	5	775		3,746	15
16	Renovate-gen'l labor AMS			2008	10,664	2,133	5	2,133		9,954	16
17	Renovate-gen'l labor AMS			2008	11,352	2,270	5	2,270		10,405	17
18	Capps-Repipe shower lines			2008	4,585	917	5	917		3,974	18
19	ABCPlumbing - major repair			2008	4,885	977	5	977		3,989	19
20	Wire building for cable			2009	6,518	652	10	652		2,553	20
21	Wire building for cable			2009	6,240	624	10	624		2,444	21
22	Wire building for cable			2009	2,800	280	10	280		1,003	22
23	ABCPlumbing - major repair			2009	17,539	877	20	877		3,435	23
24	ABC-Replace elevator shaft			2009	9,794	490	20	490		1,878	24
25	ABC-Replace elevator shaft			2009	39,178	1,959	20	1,959		7,509	25
26	Central States-Replace sprinkler alarm panel			2009	2,650	530	5	530		2,076	26
27	Patten-Major generator repair			2009	2,992	598	5	598		2,343	27
28	Patten-Major generator repair			2009	10,604	2,121	5	2,121		7,777	28
29	Fire sprinkler repair & corrections Focus Fire			2010	2,672	534	5	534		1,157	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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	
37	ABC Job 1058-Phone lines new thruout	2011	\$ 9,348	\$ 623	15	\$ 623	\$	\$ 898	37
38	ABC Job 1058-Carpet labor-children's exit	2011	2,000	133	15	133		192	38
39	ABC Job 1058-Ceramic flooring in kitchen	2011	1,369	91	15	91		131	39
40	ABC Job 1058-Structural Steel-exterior railings	2011	7,501	500	15	500		721	40
41	ABC Job 1058-Plumbing-kitchen sink and cleanout covers	2011	4,546	303	15	303		437	41
42	ABC Job 1058-concrete coring	2011	327	22	15	22		32	42
43	ABC Job 1058-Parking Lot-paving	2011	7,144	476	15	476		686	43
44	ABC Job 1058-Kitchen equipment	2011	3,542	236	15	236		340	44
45	ABC Job 1058-Finish Hardware-door kickplates, handles	2011	900	60	15	60		87	45
46	ABC Job 1058-Elevator-stainless steel cladding	2011	14,550	970	15	970		1,399	46
47	ABC Job 1058-Millwork cabinets-nurses station / work areas	2011	1,728	115	15	115		166	47
48	ABC Job 1058-Countertops-nurses station / work areas	2011	1,344	90	15	90		130	48
49	ABC Job 1058-Drywall-lower level	2011	3,398	227	15	227		327	49
50	ABC Job 1058-Smoke detectors-lower level	2011	3,365	224	15	224		323	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,051,710	\$ 274,940		\$ 274,940	\$	\$ 789,848	70

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

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		\$ 10,051,710	\$ 274,940		\$ 274,940	\$	\$ 789,848	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	Adj for ABC Related Party Profit	2008	(173)	(32)		(32)		(144)	26
27	Adj for ABC Related Party Profit	2009	(878)	(38)		(38)		(152)	27
28	Adj for ABC Related Party Profit-None	2010							28
29	Adj for ABC Related Party Profit	2011	475	28		28		42	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,137,425	\$ 276,399		\$ 276,399	\$	\$ 868,258	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	\$991,142	\$189,704	\$189,704	\$	various	\$380,494	71
72	Current Year Purchases	34,232	1,941	1,941		various	1,941	72
73	Fully Depreciated Assets	408,126	70,006	70,006		various	408,126	73
74								74
75	TOTALS	\$1,433,500	\$261,651	\$261,651	\$		\$790,561	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)	\$11,933,132	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$538,050	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$538,050	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)	\$1,662,730	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

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 EndingAnnual Rent

- 12.12/31/13\$ #####
- 13.12/31/14\$ #####
- 14.12/31/15\$ #####

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?
16. Rental Amount for movable equipment: \$12,204Description:Copy Machine Lease, Office Equipmenet Lease
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

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	\$ #####	\$ 12,435	17
18					18
19	Auto Lease GL 6890	various	713.35	8,560	19
20					20
21	TOTAL		\$ #####	\$ 20,995	21

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

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

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

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.)

12345678											
	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				33,649		33,649	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>						90,161		90,161	13	
14	TOTAL			\$		\$	\$ 123,810		\$ 123,810	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.

Col 5: PT,OT, & ST
Col 6: Supplies

13. Other: See Pg 16A

13. Col 5: Manual Input: Related Party - CPT	To Col 5	-
Other		255,666
Less: Respiratory Therapy Costs reclassified to line 10A on Pg 4A		(181,335)
Manual Input: Related Party - Prism		(22,849)
Manual Input: Related Party FECII - I.V.		-
Manual Input: Related Party FECII - Wound Care		(778)
Oxygen, from Pg 4A reclass worksheet		39,457
13. Col 6: Supplies Total	To Col 6	90,161
13. Total Line 13, Column 8		90,161
14. Total		123,810
Should tie to Page 4, Line 39, Col 8		=====

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	\$ 11,446	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,000)	1,610,088	1,610,088	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	31,973	191,954	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)	\$ 1,644,561	\$ 1,813,488	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	284,254	353,081	15
16	Equipment, at Historical Cost	226,392	1,423,159	16
17	Accumulated Depreciation (book methods)	(308,743)	(1,642,324)	17
18	Deferred Charges	94,600	520,307	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		69,677	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due from affiliates			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 296,503	\$ 10,897,442	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,941,064	\$ 12,710,930	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 529,874	\$ 539,921	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,795	20,795	28
29	Short-Term Notes Payable		89,610	29
30	Accrued Salaries Payable	331,295	331,295	30
31	Accrued Taxes Payable (excluding real estate taxes)	52,131	52,131	31
32	Accrued Real Estate Taxes(Sch.IX-B)		111,300	32
33	Accrued Interest Payable		63,139	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Exp,Due HFS,SalesTax,Etc.	52,421	52,421	36
37	Due to affiliates	1,224,752	1,224,752	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,211,268	\$ 2,485,364	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,752,139	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliates	7,265,984	6,220,284	43
44	S/holder loans, others			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,265,984	\$ 18,972,423	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,477,252	\$ 21,457,787	46
47	TOTAL EQUITY (page 18, line 24)	\$ (7,536,188)	\$ (8,746,857)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,941,064	\$ 12,710,930	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,575,746)	1
2	Restatements (describe):		2
3	Non-allowable cost or revenue adjustments recorded		3
4	after prior year report submitted:		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,575,746)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,960,442)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,960,442)	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)	\$ (7,536,188)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Village North# 0049122Report 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	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,251,122	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,251,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	30,480	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 30,480	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	(50)	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	160	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 110	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	183	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 183	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG19A	540,396	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 540,396	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,822,291	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,370,984	31
32	Health Care	3,119,731	32
33	General Administration	1,673,214	33
	B. Capital Expense		
34	Ownership	1,288,534	34
	C. Ancillary Expense		
35	Special Cost Centers	972,570	35
36	Provider Participation Fee	357,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,782,733	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,960,442)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,960,442)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,165,238	44
45	Private Pay - Net Inpatient Revenue	85,884	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,251,122	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 Village North# 0049122Report Period Beginning 01/01/2012 Ending:

Details of Page 19, Line 28

<u>Description</u>	<u>Amount</u>
Misc Income-Jury Duty-applied againset exp Pg 5A	\$ 34
Misc Income-Donations-expense disallowed page 5 already	20
Misc Income-Polling Site Reimbursement-applied againset exp Pg 5A	300
Misc Income-Record Copies-applied against exp Pg 5A	141
Day Training Income (not offset, actual costs reported)	538,310
Gain on Sale of Assets (related to prior year, not offset on Schdl V)	1,591

Line 28 Total:	<u>540,396</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	2,056	2,080	\$ 90,032	\$ 43.28	1
2	Assistant Director of Nursing	1,600	1,600	50,357	31.47	2
3	Registered Nurses	21,608	23,274	715,433	30.74	3
4	Licensed Practical Nurses	14,134	15,062	354,770	23.55	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,056	2,056	39,759	19.34	9
10	Activity Assistants	2,621	2,799	28,110	10.04	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,056	2,108	37,874	17.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,559	20,153	214,096	10.62	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	45,248	21.75	17
18	Housekeepers	9,228	10,180	111,229	10.93	18
19	Laundry	12,395	13,876	141,566	10.20	19
20	Administrator	1,280	1,280	39,973	31.23	20
21	Assistant Administrator	2,880	2,880	70,412	24.45	21
22	Other Administrative	2,080	2,080	37,204	17.89	22
23	Office Manager	2,000	2,000	42,695	21.35	23
24	Clerical	2,608	2,714	28,699	10.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,120	6,120	100,241	16.38	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	114,626	123,872	1,360,815	10.99	30
31	Medical Records					31
32	Other Health Care Unit Manager	2,336	2,336	39,050	16.72	32
33	Other(specify) Schl Nrs Lias/Res	4,244	4,244	98,150	23.13	33
34	TOTAL (lines 1 - 33)	226,567	242,794	\$ 3,645,713 *	\$ 15.02	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	flat monthly fee	\$ 22,800	1-3	35
36	Medical Director	flat monthly fee	45,125	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat monthly fee	3,284	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	flat rate/resident	131,506	11-3	44
45	Social Service Consultant	16 hours	560	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 203,275		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

STATE OF ILLINOIS

0049122

Report Period Beginning:

01/01/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Alden Village North

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>CZAJKA, CHRISTIANE D</td> <td>Administrator</td> <td>0</td> <td>\$ 39,973</td> </tr> <tr> <td>CZAJKA, CHRISTIANE D</td> <td>Asst Administrator</td> <td>0</td> <td>17,603</td> </tr> <tr> <td>WALSKI, KRISTOPHER R</td> <td>Asst Administrator</td> <td>0</td> <td>52,809</td> </tr> <tr> <td></td> <td></td> <td>0</td> <td></td> </tr> <tr> <td></td> <td></td> <td>0</td> <td></td> </tr> <tr> <td></td> <td></td> <td>0</td> <td></td> </tr> <tr> <td></td> <td></td> <td>0</td> <td></td> </tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 110,385</td> </tr> </table>				Name	Function	Ownership %	Amount	CZAJKA, CHRISTIANE D	Administrator	0	\$ 39,973	CZAJKA, CHRISTIANE D	Asst Administrator	0	17,603	WALSKI, KRISTOPHER R	Asst Administrator	0	52,809			0				0				0				0		TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,385	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 115,584</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td>86,443</td> </tr> <tr> <td>FICA Taxes</td> <td>274,629</td> </tr> <tr> <td>Employee Health Insurance</td> <td>55,345</td> </tr> <tr> <td>Employee Meals</td> <td>29,741</td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td></td> </tr> <tr> <td>Chicago Head Tax</td> <td>3,158</td> </tr> <tr> <td>Union Health & Welfare</td> <td>123,028</td> </tr> <tr> <td>Dental & Life Insurance</td> <td>1,517</td> </tr> <tr> <td>Pension & 401K Match</td> <td>36,668</td> </tr> <tr> <td>Employee Drug Testing/Vaccinations</td> <td>1,744</td> </tr> <tr> <td>Empl. Relations & Misc Payroll Costs</td> <td>5,469</td> </tr> <tr> <td>Marketing Manager Benefits Eliminated</td> <td></td> </tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 733,326</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 115,584	Unemployment Compensation Insurance	86,443	FICA Taxes	274,629	Employee Health Insurance	55,345	Employee Meals	29,741	Illinois Municipal Retirement Fund (IMRF)*		Chicago Head Tax	3,158	Union Health & Welfare	123,028	Dental & Life Insurance	1,517	Pension & 401K Match	36,668	Employee Drug Testing/Vaccinations	1,744	Empl. Relations & Misc Payroll Costs	5,469	Marketing Manager Benefits Eliminated		TOTAL (agree to Schedule V, line 22, col.8)		\$ 733,326	F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>IDPH License Fee</td> <td>\$</td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td>432</td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed 32)</td> <td>960</td> </tr> <tr> <td>Patient Background Checks 13</td> <td>130</td> </tr> <tr> <td>IL Assn of Health Care Facilities</td> <td></td> </tr> <tr> <td>Surety Bonds</td> <td>2,069</td> </tr> <tr> <td>IL Health Care Assn / APCCMN less PAC</td> <td>6,147</td> </tr> <tr> <td>Collaborative Healthcare/Sec of State/</td> <td>430</td> </tr> <tr> <td>Related party-AMS</td> <td>1,285</td> </tr> <tr> <td>Less: Public Relations Expense</td> <td>()</td> </tr> <tr> <td>Non-allowable advertising</td> <td>()</td> </tr> <tr> <td>Yellow page advertising</td> <td>()</td> </tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 11,453</td> </tr> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment	432	Health Care Worker Background Check (Indicate # of checks performed 32)	960	Patient Background Checks 13	130	IL Assn of Health Care Facilities		Surety Bonds	2,069	IL Health Care Assn / APCCMN less PAC	6,147	Collaborative Healthcare/Sec of State/	430	Related party-AMS	1,285	Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,453
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Ken Fisch	Legal Fees	2,238																																																																																																									
BDO Seidman	Tax Prep Services	8,892																																																																																																									
Comprehensive Therapeutics-Pg4	Activity consultant	840																																																																																																									
First Advantage	Tax Services	1,526																																																																																																									
Ungaretti Harris	Legal Fees	22,905																																																																																																									
Pacific Interpreters	Deposition Translation	(19)																																																																																																									
Johnson & Bell/Jackson Lewis	Legal/Legal	16,661																																																																																																									
Pathway Health Services	Clinical Consultants	11,990																																																																																																									
Renzi & Assoc	Appraisal Services	3,500																																																																																																									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 320,528																																																																																																									

HFS 3745 (N-4-99)

IL478-2471

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	Painting	7/12	2,348	3						391	783	783	391
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 104,589		\$	\$ 17,851	\$ 33,099	\$ 33,441	\$ 15,790	\$ 1,226	\$ 1,276	\$ 1,276	\$ 610

XX. GENERAL INFORMATION:

- (1)

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

RN/LPN=No; HabAides

(13)
- (2)

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

Yes

If YES, give association name and amount.

IHCA=\$5,797; APCCMN=\$350
- (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.

\$ 24,048

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.

\$ 357,700

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.

\$ 29,741

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?

Yes

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